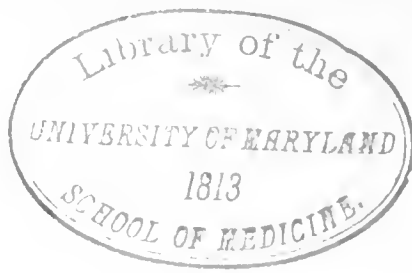
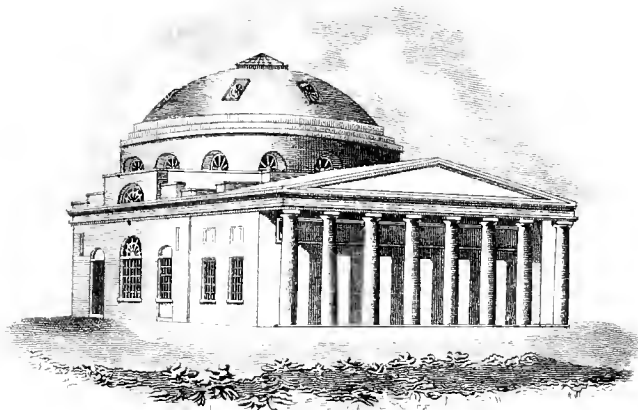




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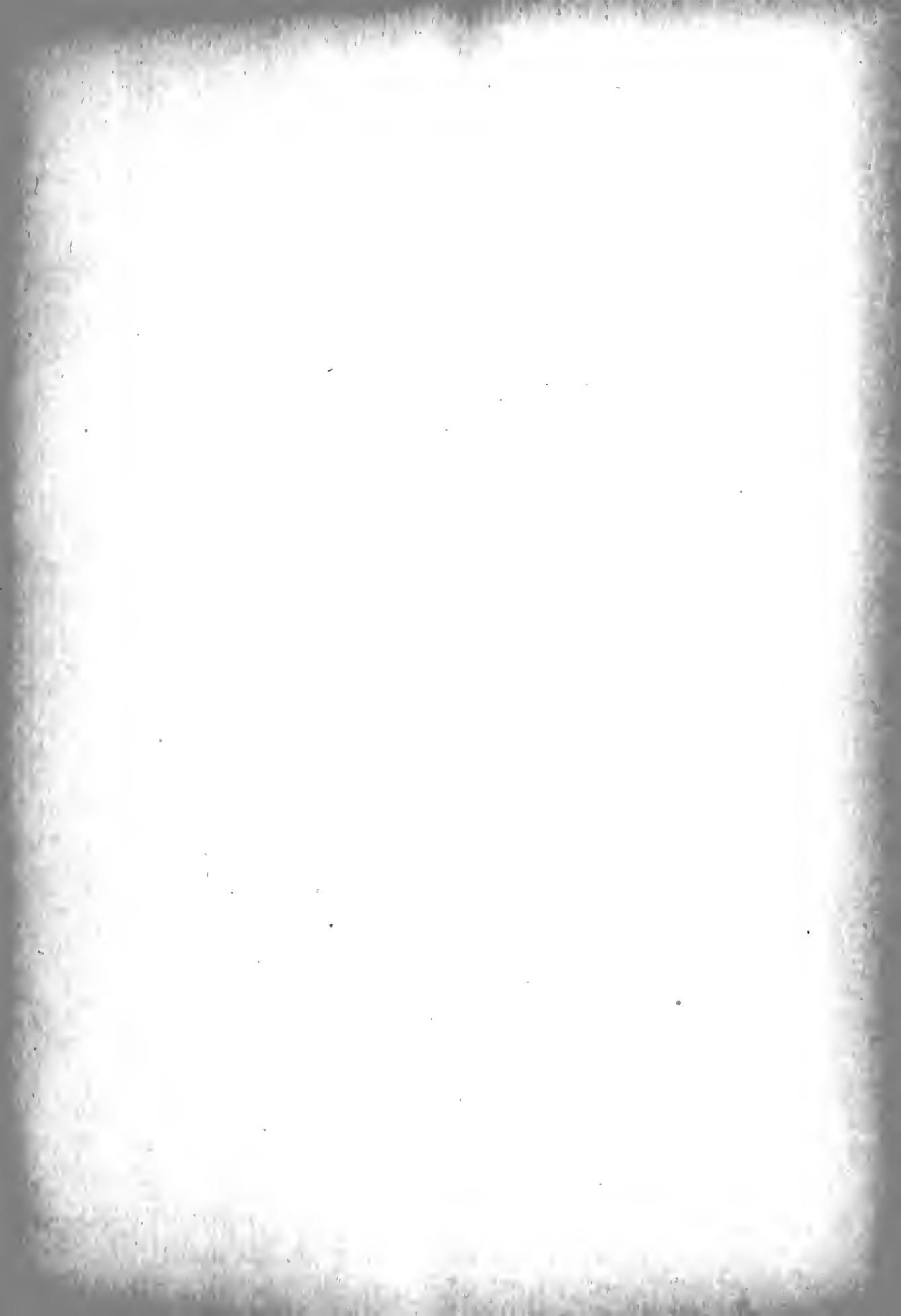


University of Maryland











# THE HOSPITAL BULLETIN

OF THE  
UNIVERSITY OF MARYLAND

VOL. VIII.

MARCH 15, 1912.

No. 1

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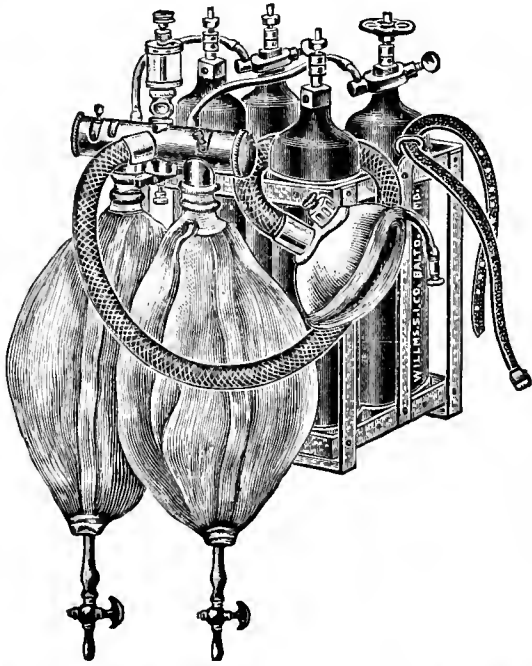
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Vol. VIII

BALTIMORE, MD., MARCH 15, 1912.

No. 1

## THE PUBLIC SHOULD BE EDUCATED IN REGARD TO CANCER THE SAME AS IS BEING DONE IN TUBERCU- LOSIS.

By A. ALDRIDGE MATTHEWS, M.D.

Cancer is almost the only disease which is on the increase in the civilized world. Whether this is a true increase or whether it is due to the profession recognizing the disease more accurately, and the statistics being better kept by the profession, by institutions and by the Government, I cannot say, but I am inclined to think it is the latter: but nevertheless we have to admit there is a decided increase of cancer mortality in the records of today over former ones.

This world-wide disease is not confined to any certain people, but occurs among all races of mankind, and is indeed found throughout the vertebrate kingdom. Domestic animals are more susceptible to it than animals in the wild state. Dr. C. W. Mayo explains this fact as being due to their longer life, the disease being more common in the relatively aged in both man and animal.

The medical profession, with the aid of the press, the National Government and the anti-tuberculosis societies, have put on foot a crusade against tuberculosis, and it is being brought forcefully to the laity, who are taking an active part in causing a universal reduction in tuberculosis. The public must be educated along these lines—that cancer is a local disease in its incipency, and is curable when properly cared for in the majority of cases; until this is done we cannot hope to reduce the cancer mortality. If the laity were properly informed in regard to this, it would make it much easier and more satisfactory to reduce and keep down the mortality of this dreaded disease, and this education must come through the physician, directly and indirectly; so the sooner it is begun, the sooner we may expect results.

There are precancerous conditions which, if taken hold of when such, would prevent cancer formation. Most cancer deaths are due to delay, and are therefore unnecessary. The first or curable stage has been ignored, and cure has been sought only when the disease has become incurable. This delay is not always due to the patient himself, but often to his physician, either directly or by advising him to wait and see what the future will develop, or by temporizing with some placebo which he knows is valueless, but which the patient ignorantly supposes to be curative.

As Greenough has said (referring to benign breast tumors), no tumor is innocent and incapable of harm until removed.

Childe of Portsmouth, England, more than any other English or American writer, has emphasized the true importance of the early signs of cancer. He calls them danger signals, and compares them with the danger signals in other conditions. Danger signals in cancer, just as on the railroad or at sea, mean that there must be immediate and efficient action in order to prevent disaster. The physician who neglects the danger signal in a cancer patient is just as much responsible for the disaster to his patient as the engineer is to his passenger if he neglects the danger signal and runs into an open switch. Childe's danger signals are briefly as follows:

1. Cancer of the breast. Here the danger signal is a small lump or thickening of any kind. In a woman over 35 years old this lump is a cancer from the start in at least 90 per cent. of cases. In a woman of any age the finding of a lump in the breast should be immediately followed by its removal.

2. Cancer of the uterus. The danger signal here is an irregular bleeding, especially after the menopause, or the onset of a discharge in a woman who has been free from it previously, or the change in character of a previously present discharge so that it becomes more profuse, more foul or more irritating.

3. Cancer of the lip, mouth and tongue. The danger signal here is any sore that will not heal.

4. Cancer of the skin. The danger signal here is any sore that will not promptly heal, or any wart or mole which suddenly begins to grow rapidly.

5. Cancer of the stomach and intestines. Here the danger signals are not so apparent as on the surface of the body. After 40 years of age the onset of obstinate indigestion, persistent colicky pains in the abdomen, persistent diarrhea, and especially vomiting or the passage of blood in the stools, are the danger signals, and their real cause must be determined at once.

It is unfortunately too true that a large number of people notice these danger signals themselves, but do not apply to a physician until ample time has been given for the incurable stage to develop.

Quoting from Childe again, it is unfortunate that a patient will run to a dentist with a toothache much more quickly than to a physician on account of symptoms pointing to a malady which, if neglected, will prove fatal. Many people will not bother with the early warning symptoms if there is no pain and no impairment in general health. The patient waits for these to come on before they admit the possibility of cancer, and, unfortunately, the physician may countenance a similar delay. Yet there is nothing more certain than that pain and cachexia are never present in the early curable stages, but come on only when the disease is hopeless, the early danger signals have been neglected and help has been asked only on the appearance of impending death.

One of the most common sites for cancer in the female is the breast. At a meeting of the American Surgical Association held in May, 1907, a symposium on cancer of the breast showed the percentage of cures following the radical breast operation was from 20 to 40 per cent. In cases where there was no axillary involvement at the time of operation the percentage has increased from 70 to 80 per cent. Eighty per cent. of tumors of the breast are malignant or become so.

Drs. Greenough's, Simmons' and Barry's report from Massachusetts General Hospital show that early operation done and not complete gave better results than a radical operation done late or after axillary involvement, and their total cures were 20 per cent. The conclusion to be drawn from this is that a radical operation should be done as early as possible.

In England the statistics for 1905 show that cancer is more fatal to women than tuberculosis, there being 100 deaths per 100,000 for the former to 94 for the latter. The English statistics further show that while at present more women are affected with cancer than men, the proportion of males having cancer has increased more rapidly since 1850 than females. Omitting carcinoma of the breast and uterus, the disease is more common in male than in female. The English statistics for 1906 show that 1 in 11 in all men and 1 in 8 of all women 35 years of age or more die eventually of cancer. The statistics of the United States are not as complete as those of England. They show deaths from malignant disease in 1850 were 9 per 100,000, while in 1900 they had increased to 43, or nearly fivefold in 50 years.

The deaths from cancer alone in 1890 were 47 per 100,000, but had increased to 60 per 100,000 in 1900. The deaths from tuberculosis in 1890 were 245 per 100,000, but had decreased to 187 per 100,000 in 1900. In New York State, where very good statistical records are kept, these showed an increased mortality in proportion to the population 25.4 in the 10 years from 1896 to 1906, while the tuberculosis ratio decreased 4.9. The death proportion in the State of Minnesota for the year 1908 was 1 in 17 from cancer. The United States census report for 1900 showed that 1 death in 29 was due to cancer.

Since 1880 the comparatively excellent figures of the State of Massachusetts show an increase from 5.21 to 8.80 for the same period. According to the Government mortality statistics of the twelfth census, cancer had made a gain of 12.1 deaths per 100,000 during the past 10 years, and in 1909 cancer held ninth place as a factor in the cause of death. It is further worth noticing that cancer showed an increase in every State except Maryland and South Dakota from 1908 to 1909.

Kelly claims that the uterus is the most frequent site of primary carcinoma, although he gives no figures to prove his statement. There are many authors who disagree with him on this subject. He also states that the fundus is more likely to be attacked at and after the menopause, while the cervix is more susceptible while the menses persist.

Martin in "Osler's System" states that about one-half of all cancers arise in the stomach.

Reich's figures at Hamburg (1879 to 1895) disclose that 50.2 per cent. of all cancers were gas-

tric, while gastro-intestinal tract furnished 75 per cent. to 80 per cent. of all carcinomata. The combined analysis of 70,000 cases of cancer demonstrated over 21,000 (33 per cent.) to be gastric.

Tuttle claims that 80 per cent. of all cancers of the intestines occur in the rectum.

We must not forget that cancer occurs in early life as well as later. While it is true the vast majority of cancers occur in the latter half of life, it has occurred in infancy. Reigle reported one case of cancer of the stomach in a child six weeks old.

In New York there were six deaths reported in 1900 from cancer in children under 10 years of age.

According to Fisk, this increase is well shown for each age period as indicated in the following table:

Age.	1880.	1907.	Per cent. increase.
Below 20 years.....	0.19	0.21	10
20 to 30 years.....	0.45	0.36	46
30 to 40 years.....	0.2	3.	50
50 to 60 years.....	11.8	22.9	94
Over 60 years.....	2.4	45.8	90

The relation of carcinoma to sexes presents some important facts. Bland of Philadelphia found 15,379 cases of cancer ending fatally from 1879 to 1904; that the deaths among women were twice as numerous as those among men. This was due to the great frequency of the cancer of the uterus and breast.

Welch reports the proportion of gastric cancers being five in men to four in women.

Tuttle claims that 60 per cent. of rectal cancers are in men.

Wile of New York reporting from the census claims 5.5 per cent. of all deaths in the male for the year 1909 as compared with 5.1 per cent. in 1908. For females 8.1 per cent. of all deaths as compared with 7.5 per cent. in 1908 were due to cancer.

Well might the Registrar-General of England generalize by stating that of women living at the age of 36 years and upward one out of nine will die of cancer.

Templeman has called attention to the fact that cancer deaths have doubled in the past 25 years, going from 7.27 in 10,000 of population to 16.92 in 10,000 population over 20 years of age.

I think possibly the best definition of cancer

has been given by L. S. Pilcher, who describes it as follows:

"It is a lawless proliferation of the pre-existing epithelial cells in luxuriant, irregular-arranged masses that invade underlying and surrounding tissue primarily, destroying them and finally themselves, attaining a mass that can no longer be adequately nourished by an accessible blood supply, and which itself then falls into central decay, while at the periphery the process still goes on."

These growths closely resemble the embryonic development of cells in the power of cell multiplication and in the continuance of type in the metastasis and transplantation of the growth.

It is generally supposed that a carcinoma often develops from severe injury, but there is no evidence that single injury does any more than call attention for the first time to a pre-existing tumor or hasten the growth of an early malignancy. Trauma as a cause has not been established by any of our statistics. Dr. C. W. Mayo says it is an apparent fact that in classifying the causes which may render precancerous conditions active we should include nerve fatigue, such as is seen in the modern business world. The organs of convenience, *i. e.*, stomach, bladder and large bowel, which were added late to primitive life, have poor cell resistance and are prone to cancer degeneration.

It is a well-recognized fact that cancer often develops from chronic irritation, such as epithelioma of the lip, from irritations caused by the pipe stem in inveterate smokers, or by a jagged tooth; or fibromyomata of the uterus and breast, ulcer of stomach and bowel diverticulitis, and many other conditions of such character. MacCarty of Rochester has found in a study of 5000 appendices which had been removed for chronic subacute appendicitis that 0.5 per cent. of these were carcinomatous, and the diagnosis of 23 per cent. of these was not suspected at the time of removal, but detected later in the laboratory.

I have said nothing as to the etiology, because I have nothing new to say.

The occurrence of the majority of cancers after 30 years of age is rather against Cohnheim's theory of cell inclusion. The effect of dietary indiscretions is suggestive in the fact that over 40 per cent. of all cancers are localized in the alimentary tract. This is no more conclusive than asserting

trauma as a factor because over 20 per cent. are mammary or uterine.

Heredity I do not think plays any important part or has any bearing on the etiology.

The present search for the parasitic origin of the disease has received but little encouragement. Whether the present era of animal experiments will link carcinoma to tuberculosis in some way, as the recent experiments of Dickson, Smith and Fox have suggested, or whether the disease may be transmitted through the agency of some yet undiscovered parasite, statistics give no testimony. We should not give up this idea entirely, for practically all of our acute diseases with which the people of our universe are affected are due to bacterial infection, and therefore we should continue to search diligently for the germ of cancer so that an antagonistic remedy may be developed for its cure.

We cannot hope to cure cancer with our present knowledge of its cause. The most optimistic internist cannot claim a single cure. Serum therapy has revolutionized the treatment of many diseases, but has been of no help in cancer. The X-ray, which at first promised so much, is now regarded as of little value except in the most superficial skin cancers. The treatment of cancer by radium is in the experimental stage.

The question has been asked me a number of times why cancer did not affect the young. It does, as I stated above, but not often, and this reason is possibly due to vigorous growth of the cells in the young, which are less subject to cancer, but more susceptible to poison; but the active lymphatics of the young cause a rapid dissemination of the disease when it does occur. In very old people cancer travels very slowly on account of the obliterated and sclerosed condition of the lymphatics, and the same obtains, as a rule in the various infections of the old. I have noticed a number of times in cases of cancer about the face and the breast in the aged that its progress, as a rule, was very slow.

The possible reason why the laity are often so afraid to have precancerous conditions removed is that they know of cases which have been operated upon, and the condition progresses just the same until death. The reason for this is, of course, delay.

The public should be instructed that the danger is not in the operation, but in the delay. Another reason why distrust in cancer operations exists

is that hopeless cases often go to the surgeon and are operated upon where no good results could be expected, and consequently the death is charged more to surgery than to the true cause, whereas if the patients had not been operated upon they might have served as living examples of delay.

Therefore, we should put every effort forward to inform the public in regard to the prophylactic treatment of cancer. I hope and believe that in the near future there will be a better treatment for cancer than the knife, but at present it is the only true conqueror, so far as we have one, and this conquest is only made when the attack is made in the precancerous or incipient stage.

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### IS SYPHILIS HEREDITARY?

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By E. K. TULLIDGE,  
*Baltimore, Md.*

---

To discuss syphilis as a hereditary disease we must first define disease, which, according to McFarland, "is the inharmonious relation of the individual to his environment," and second, obtain a clear, distinct idea of the term hereditary.

In the true biological sense this term is much misused in medicine and surgery, being applied to many pre-natal conditions that have nothing to do with it. In biology the term "hereditary" is used to describe conditions transferred from parent to offspring by peculiarities of the germ plasm. It does not refer to accidental conditions of pre-natal life by which the health or perfection of the offspring is affected. These conditions are termed "congenital."

Many of the present-day biologists differ as to whether acquired characteristics can be transmitted to the offspring or not. If not, then there can be no such thing as a hereditary disease or deformity. Lamarck and Darwin believed firmly in inheritance and in the transmission of acquired characteristics; Darwin making it the basis of his theory of evolution.

Weissmann, Francis Galton, Adami, and perhaps the majority of the present-day biologists, doubt or disbelieve its possibility. It seems certain that experimental characteristics, i. e., mutilations such as result from circumcision, amputations, nucleations, etc., are not transmitted, but it appears certain that spontaneously acquired variations from the normal may be transmitted. Adami has suggested that heredity may be ex-



plained upon the assumption that the idioplasm, or that part of the protoplasm possessing vital properties, is composed of a mass of molecules which form a central ring, to which side rings may be attached, or from which they may be detached without alteration of the central primitive ring. Environment causes the central ring to have attached certain side chain combinations, and in this way the modifications of the tissue cells are consummated. In the same way environment conditions lead to further modifications in the forms of new lateral chain combinations. Those lateral chains that are last developed are the least stable and the most readily lost, while those which have been attached for a long period of time are not readily loosened. Thus it is that conditions produced by the lateral chains which have been active for generations tend to persist, while those recent changes in structure or alterations of environment produce with the general idioplasm combinations too weak to be transmitted.

The hereditary conditions thus far considered refer to immediate peculiarities, as the possession by the parent of a peculiarly situated lock of white hair, which peculiarity is transmitted to the child, or the parent has six fingers or toes, which also appear in the offspring.

In connection with certain diseases, hereditary conditions are, however, more remote, thus in hæmophilia, or "Bleeders' disease," we find a certain mode of transmission. The male suffering from the conditions may not transmit it to his immediate offspring, though his daughters are very apt to transmit it to their sons, thus skipping a generation.

Consanguinity is a dangerous hereditary condition from its tendency to accentuate family weakness, this danger being in proportion to the deviations from normal of those concerned.

Atavism is another peculiarity in which the traits of remote ancestors may make their appearance, such as flat-foot, receding forehead, prognathism or protrusion of the lower jaw, and massive projecting ears, all characteristics of the lower animals and simian race.

Many pathologists divide the subject of heredity into two divisions, namely, true heredity, or that condition just discussed, and false or apparent heredity, commonly mistaken for heredity proper, and to which is accredited those modifications of the embryo by conditions occurring in pre-natal life. Thus certain infectious diseases, such as

smallpox and syphilis, may be transferred from mother to foetus through the placental circulation and cause the disease acquired from the parent.

Those predispositions or tendencies which occur in the offsprings of tuberculous, cancerous and neurasthenic subjects may depend upon transmitted physiologic peculiarities, or may be nothing more than the result of lack of vigor of the germ plasma, whose development results in a feeble individual.

Human ova are free, or almost free, from yolk, and are relatively very small. There has not been a single observation, according to Adami, showing that the mammalian ova is phagocytic, i. e., able to take up foreign particles. That minute spermatazoa should act as carriers is still more unlikely, and the possibility that they do so has been negatived by Gärtner.

Adami has shown that the minimum number of tubercle bacilli that will set up peritoneal infection in the guinea pig is eight; in the rabbit 24 to 30, and Gärtner, after obtaining the seminal ejaculations from tuberculous guinea pigs, found that only five out of thirty ejaculations contained a sufficient number of bacilli to cause the disease. Rohlff did not once succeed in rendering rabbits tuberculous by injecting them with semen of men suffering with phthisis. Gärtner concludes that the semen emitted by a phthical patient does not on the average contain as many as 10 bacilli.

From these experiments of Rohlff and Gaertner, Adami calculates that on the average, human seminal ejaculations contain more than 226,000,000 spermatazoa, and if the semen contained not 10, but 1000 spirochetes, the chances that an individual spermatazoa fertilizing the ovum should bear with it a spirochete and so lead to germinal infection are as one is to 226,000. If 1,000,000 ratio would be 1.226, only one of 85,000,000,000 spermatazoa having a chance of fertilizing an ovum. One may draw his own conclusions as to the chance of a spermatozoon conveying the disease from father to the offspring. It is so absurdly minute as to be almost nil.

That cases of syphilis in the new-born are most often of late intrauterine acquirement is made evident by Chiari, who states that in 90 per cent. of infants presenting signs of syphilis the liver is the seat of the most syphilitic disturbances. Infection through the placenta amply explains the conditions in infants, for all the blood on its way through the placenta passes through the liver,

which is thus the organ first subjected to infection. Adami specifically states that whenever there are active and specific manifestations of tuberculosis, syphilis or other infective diseases of the newborn child, the condition is of intrauterine acquirement, and not inherited. This statement he supports by referring to the various stages to which one may find the disease developed in the newborn.

After an interesting series of observations of experiments on healthy does, Freichmann concluded that bacilli introduced into the uterus outside of the amnion may some day later be found in the amniotic fluid, whether through the placenta (from maternal affection), through the wall of the foetal sac, or by passage into the developing ovum before the sac has developed, organisms may infect the embryo. These various means are adequate to explain the phenomenon without calling upon improbable infection of the ovum or spermatozoon prior to fertilization.

Children of syphilitic or tuberculous parentage who exhibit certain stigma as foetal cachexia, malnutrition, senile expression, senescence, even malformations, are those who have acquired these characteristics presumably by the germ plasm presenting modifications and disturbances peculiar to the parental germ cell.

After weighing the many arguments upon the passage of foreign substances through the placenta advanced by Bonnett, Hofbauer, Wallgren, Polano, Schmidlechner, Liedauch and others who have experimentally proven the transmission of iron, fat, albumosis, toxins of diphtheria and tetanus, the organisms of pneumonia, relapsing fever, various infections due to pyogenic organisms and typhoid fever, which of the many mentioned is most frequently transmitted, due no doubt to its motility, it is apparent that the functions of the placenta are not limited to mere absorption by osmosis. The adverse condition, namely, the transmission of materials from the foetus to the mother, has been demonstrated by Savoy and Guserow. Therefore, we may safely say that it seems hardly probable that infection of the foetus may occur without some transmission of the organisms, or their toxins, to the mother, and vice versa.

The reason why the manifestations are not apparent at the time of delivery is due probably to a latent stage or period in which the spirochete de-

velops a provisional immunity only to be followed by manifestations of the disease in later life.

Keyes states, after citing "Colles's law," that the mother of such a syphilitic child (Colles's Child), although herself remaining healthy many years, almost invariably ultimately breaks out with tertiary syphilis (*choc en retour*), and that therefore the mother of a syphilitic child, even though she remain apparently sound, is syphilitic.

In conclusion, let us suppose that should a father transmit the disease apparently only to the foetus by the fertilization of an ovum by a spermatozoon conveying a spirochete, and to which spermatozoon has been given its one 85,000,000,000 of a chance, according to Adami, and should this one spirochete be sufficient in itself to produce the disease, which is highly improbable and unlikely, the infection would not only be confined to the embryo, but would involve the placenta as well, and from there be transmitted to the mother. The condition would be a disease not the result of peculiarities of the germ plasm, but the result of an exogenous or mechanical infection, which we must admit in the true biological sense is only congenital.

The explanation of the erroneous use of the word "hereditary" in connection with this disease by the profession is probably due to the only recently acknowledged definition of the term.

---

The following letter has been received by Dr. Randolph Winslow from Dr. Judson J. Davis, class of 1891, of Beaufort, N. C.:

*Dr. Randolph Winslow,  
Baltimore, Md.:*

Dear Sir—As an old friend and well-wisher of my old "Alma Mater," I am writing you to ask if you can find two or three young M.D.'s who will take up some good practices in the eastern section of this State. There are three or four fine openings in this section for young men of good character who wish to get in a work that will bring in money at once. I have nothing to sell, and only have the interest of my old college and my native section at heart. If any of the young men who are to graduate this spring wish further information about these openings, I will gladly give same upon request.

With best wishes for you and the University,

Yours very truly,

J. J. Davis.

AN ANALYTICAL STUDY OF FIFTY  
CASES TREATED IN THE GASTRO-  
ENTEROLOGICAL DEPARTMENT OF  
THE UNIVERSITY OF MARYLAND—  
REVIEWED WITH SPECIAL ATTEN-  
TION TO THE ANTHROPOMETRIC  
MEASUREMENTS.

By ALBERT HYNSON CARROLL, M.D.,

and

EDW. A. LOOPER and EDW. P. KOLB,  
*Class of 1912.*

Any new method or aid in the diagnosis of pathological conditions is not only of interest to the specialist, but to the profession as a whole.

The general practitioner appreciates and makes use of the Widal test in typhoid, and the Wasserman reaction in luetic conditions.

The obstetrician often can predict the outcome of a definite case, basing his prognosis on a knowledge of the pelvic measurements.

The gastro-enterologist has developed a valuable aid in the diagnosis of splanchnoptosis by studying the anthropometric measurements, and in his effort to arrive at an index.

Becher and Lenhoff obtained an index which was arrived at by dividing the jugulo-pubic distance by the circumference of the waist, and multiplying this by 100. The higher the index, the smaller is the capacity of the thoracic cavity. The error lies here in measuring over and around such a variable part of the anatomy as the abdomen.

R. S. Smith\* based his observations on the varying depths of the thoracic cavity. His investigations showed that in enteroptotic women the depth ranged from 13 to 17 cm., while in vigorous ones it was from 16 to 20 cm. B. Stiller, as early as 1896, pointed out the hereditary condition and elaborated the "floating tenth rib" idea, an anomaly often occurring in the habitus enteroptoticus.

Hemmeter, in attempting to arrive at an index, has taken measurements from fixed bony landmarks. The measurements given in this report are obtained according to his method. Although the number of cases investigated is small, the results are significant.

The mass of figures obtained in any such series of measurements soon become unwieldy and are perhaps of value mostly for statistical purposes. Although the securing of such data is quite tedious, the study is a most interesting one, and serves also to give more accurate information as to the relationship existing between the various forms of neuroses associated with splanchnoptosis.

The size and form of the thorax as seen and estimated by such measurements, indicates closely the position of the abdominal viscera, and although we can not predict with mathematical exactness the position of the viscera, it will be found to correspond very closely indeed to the outward signs.

Visceral prolapse may be either congenital or acquired. When acquired it is usually the result of child-bearing or of excessive hard work.

In the congenital form I think that a far greater number of males are affected than is generally suspected. Nearly all of the observers constantly refer to the "enteroptotic woman." In our clinic we treat almost as many males as females for prolapsed viscera.

In congenital splanchnoptosis at least, the displacements accompany a lessened capacity of the thoracic cavity, which is primarily determined by the structure of its bony framework. And when such displacements are corrected the neuroses accompanying such displacements are quite frequently eliminated or improved. At the same time those forces which were lacking, for the proper development of the thoracic walls exert a profound effect on the abdominal musculature, and those supports which normally hold the viscera in position.

W. J. Butler† reviews the previous literature and adds some interesting observations concerning the acquired as well as the hereditary form of the enteroptotic habit. He believes that evidences are observable during childhood, but that actual ptoses are practically first seen at the period of puberty.

It is not a satisfactory state of affairs to be content alone to relieve this condition which often only evidences itself in later life, but we should seek ways of preventing its full development.

The frail child should be watched, and its tendencies more intelligently fought by maintaining a fair state of nutrition in order to direct

\**Jour. A. M. A.*, October, 1910.

†*Jour. A. M. A.*, December, 1910.

it to a more vigorous adult condition. Much has been said of late regarding treatment but I have not seen systematic muscular exercises advocated for such children. It appears to me that if, in the frail child, properly directed exercises; the kind that would tend to increase the diameters by strengthening the respiratory muscles, and hence the capacity of the chest, and which would develop the muscles in the abdominal walls were instituted, many cases which in adult life are classed as suffering with Glenard's disease, would escape with none or only a few symptoms of this distressing condition.

In the analyses of these gastro-enterological cases attention has been especially directed to the study of the anthropometric measurements. This collection does not consist of a chosen group, but represents rather fairly the type of cases coming before our clinic at the University of Maryland from year to year.

Each of these histories was prepared by two students working in the dispensary clinic under direction, and later it was read by one of them before the entire class and criticised at the weekly clinic. In nearly every case the patient was presented also at this time and seen by Dr. J. C. Hemmeter while the history was being read. Any suggestions or alterations then made by him were incorporated before it was finally accepted and filed for future reference.

It is interesting to know that 16 per cent. were cases of gastropnoxis or enteropnoxis and that 68 per cent. were cases of hypochlorhydria or were anacid in character. Eight per cent. were carcinoma and 10 per cent. were cases of acute gastritis. In one case of lead poisoning the gastric symptoms were marked, but there was only a slight wrist drop and no blue line on the gums. In an undiagnosed but carefully studied case, with no etiological factors discoverable to explain a persistent vomiting of months' duration, a recent operation in this hospital discovered a gummatous testicle. There was no history of lues, and any venereal disease had been stoutly denied by the patient, nor was there any clinical evidence of specific trouble. Several gastric and one duodenal ulcer were diagnosed and operated on by Dr. J. Holmes Smith and Dr. St. Clair Spruill.

The "X-ray bismuth meal" method was of decided value in confirming the diagnosis in several ulcer cases and in one of spasm of the cardiac orifice

of the stomach, but in a case of post-operative "viscous circle vomiting" the shadow picture was of no diagnostic value.\*

#### SPLANCHNOPTOSIS GROUP.

In this group (16 per cent. of the whole number) the anthropometric measurements showed marked deviations from the distances between established bony landmarks in normal individuals.

It is now generally accepted that when the infrasternal angle, *i. e.*, the angle formed by drawing straight lines from the extremities of the tenth ribs to the xyphoid, is narrow and measures  $75^\circ$  or less, that a displacement of the viscera may be present. If with the above small angle one or both tenth ribs, Stillers sign, are movable or floating, expectations are heightened. Again, if the base of a triangle which has for its apex the xyphoid and for its sides lines drawn from the xyphoid to the two ant. sup. spines of the ilium is nine and one-half inches or over, and the chest is narrowed in both its transverse and arterio-posterior diameters, a positive diagnosis can often be predicted from inspection alone.

In these cases the angle averaged  $64.5^\circ$ .

The anthropometric measurements averaged as follows:

From manubrium to xyphoid, 8.15 inches.

From manubrium to umbilicus, 14.43 inches.

From manubrium to symphysis, 21.19 inches.

From xyphoid to right ant. sup. spin. ilium, 11 inches.

From xyphoid to left ant. sup. spin. ilium, 10.9 inches.

The distance from "spine to spine" was 9.75 inches.

The circumference of the chest at the level of the xyphoid was only 29.65 inches.

The weight averaged 121 pounds and the height 5 feet 6 inches.

The youngest was 27 years and the oldest was 48, with a combined average of 40.

Of these, 35 per cent. were women, 75 per cent. were white and the remainder were colored.

The floating tenth rib, which has been mentioned previously, occurred in 65 per cent. of these cases, 50 per cent. having bilateral movable tenth ribs.

It will be noted that the infrasternal angle is

\*It is to be remembered that to this clinic and to Dr. Hemmeter, who was aided in the laboratories by Dr. Frank Martin, belongs the honor of originating and first calling attention to this method, although other observers later have rediscovered his method.

small. In no case was it as great as  $75^{\circ}$ . In only a few of these cases were both tenth ribs firmly attached. The left was more often freely movable than the right.

There was a noticeable narrowing in both the transverse and in the antero-posterior diameters of the thorax, with a marked elongation of this structure.

This observation is of distinct diagnostic significance as regards congenital enteroptosis, and was associated, as is almost universally the case, with marked infirmities of the entire nervous system. In all these cases the stomach was markedly displaced, and in several instances the greater curvature extended to the level of the pelvic brim.

The heart was also noted to be displaced toward the middle of the thorax in these gastropnoxis cases where the lateral and antero-posterior diameters were narrowed. About 33 per cent. of these cases exhibited associated neurasthenic conditions.

In 36 per cent. of these cases there was a diminished secretion of HCl, but in one case there was a hyperchlorhydria of  $38^{\circ}$ . The total acidity, combined acids and acid salts averaged  $45^{\circ}$ . In all these cases mucus was present in the test meals or in the washings, and often in large amount.

The Oppler Boas bacillus was found in several cases in which there was no suspicion or evidence of malignancy.

The "modified glyco-tryptophan" test for cancer was made in a number of suspicious cases, but the results were negative.

*Chronic Mucous Gastritis.*—Sixty-eight per cent. of these cases were chronic in character. This high percentage can, however, be accounted for by the fact that each case is kept under observation for a sufficient period to make a fairly accurate diagnosis. Chronic cases naturally return a sufficient number of times to allow of a urinary, fecal, complete physical and blood examination being made, as well as an analysis of the stomach contents after test meals.

Acute attacks of gastritis, which are, however, often quite transient in character and frequently relieved by a few treatments, neglect to return until a later date, if at all, for discharge. This renders the data already obtained valueless. Hence the high average per cent. of chronic cases.

In these cases of chronic gastritis 46 per cent. showed a condition of an acidity; 33 per cent. showed a condition of hypoauidity; 21 per cent.

showed a condition of hyperacidity. The total acidity averaged  $33.95^{\circ}$ . There were nearly twice as many males as females; 52 per cent. were white and 48 per cent. were colored.

The anthropometric measurements of the above class were:

M. to N., 8.02 inches.

M. to U., 14.24 inches.

M. to S., 19.65 inches.

N. to R. S. S., 10.91 inches.

N. to L. S. S., 10.88 inches.

S. to S., 9.61 inches.

C. at N., 30.91 inches.

A. at N.,  $77.34^{\circ}$ .

Weight, 131.6 pounds; height, 5 feet  $5\frac{3}{4}$  inches; age, 36 years.

It will be observed here that the length of the line from the manubrium to the symphysis is only 19.65 inches, while in the enteroptosis group it was 21.19 inches. Also the circumference at N. was less in the enteroptosis group, being only 29.65 inches. The distance between the spines of the ilium is also less in this last group, while the height is practically the same in both. The angle in this second series also exceeded the first group by  $13^{\circ}$ , while the patients averaged 10 pounds heavier.

#### CARCINOMA GROUP.

Measurements averaged:

M. to N., 9 inches.

M. to U., 15.25 inches.

M. to S., 21.89 inches.

N. to R. S., 11.12 inches.

N. to L. S., 11.12 inches.

S. to S., 10.62 inches.

C. at N., 31 inches.

Angle at N.,  $82.5^{\circ}$ .

Weight, 129 pounds; age, 47 years.

Three white; one colored; one male; three females.

There was an absence of HCl in all these cases. Oppler Boas bacillus was present in three of them. Blood was found in only one case.

#### ACUTE GASTRITIS.

Measurements:

M. to N., 7.9 inches.

M. to U., 14 inches.

M. to S., 19.41 inches.

N. to R. S. S., 10.66 inches.

N. to L. S. S., 10.66 inches.

S. to S., 9.33 inches.

C. at X., 30.33 inches.

Height, 5 feet 6½ inches; weight, 139 pounds; age, 28 years.

HCl was diminished in three-fifths of these cases; two-fifths showed an anacid condition.

Among the rarer diseases which were discovered after the patient had applied for relief of "stomach trouble" was one case of tubercular and another of amebic dysentery. There was one case of gastric crices with *tabes dorsalis*, one of true gastralgia, and many which were secondary to chronic appendicitis, tubercular invasion, pelvic disorders, floating kidney, and so on.

One ulcer case showed a hyperchlorhydria of 90° free HCl. There was one case in which rumination accompanied a hyperacidity, and one of wind swallowing.

The average measurements for the entire group were as follows:

M. to X., 8.34 inches.

M. to U., 12.46 inches.

M. to S., 20.50 inches.

X. to R. S. S., 10.74 inches.

X. to L. S. S., 10.71 inches.

S. to S., 9.74 inches.

C. at X., 30.71 inches.

Angle at X., 77.09°.

The smallest substernal angle was 45°; the largest was 95°.

Four per cent. of the angles were between 90° and 100°; 36 per cent. of the angles were between 90° and 80°; 42 per cent. of the angles were between 80° and 70°; 10 per cent. of the angles were between 70° and 60°; 2 per cent. of the angles were between 60° and 50°; 2 per cent. of the angles were between 50° and 40°.

The average age of these patients was 37 years. The youngest was 13 and the oldest 57. The average weight was only 131.5 pounds, and the height was 5 feet 5¼ inches.

It was interesting to note that in many of the cases in which enteroptosis existed there had been no previous history obtainable of marked or at times of any real gastric disturbances until shortly before applying for treatment. These cases often, from their general appearance, do not suggest a condition of displaced viscera until discovered. The diagnosis then should be as easily made as is the condition of contracted pelvis to the obstetrician or the probable present or past existence of adenoids to the rhinologist.

These cases fairly well represent the clinical material available for study, as they are similar to the class of patients presenting themselves from year to year at the dispensary clinic, where over 1700 treatments were given in the "stomach box" alone to over 500 patients in 1910.

Of these, 65 per cent. were males, 35 per cent. females, 67 per cent. white and 33 per cent. colored; 72 per cent. were married. The youngest treated was 12 years old, and the oldest 67, the average being 34 years, and the average above 30 was 42 years. Over 50 distinct occupations were represented, and of these "laborers, housewives and tailors" were far in the majority.

There has been but little effort in this analysis to draw any conclusions. We endeavored only to arrive at averages in regards to age, sex, occupations, anthropometric measurements, chemical examination of gastric contents, etc.

## THE SYMPTOMATOLOGY OF TYPHOID FEVER AND ITS COMPLICATIONS.

By C. W. RAUSCHENBACH,  
*Senior Medical Student.*

In the consideration of the symptomatology of typhoid fever it should be borne in mind that typhoid, or enteric, fever varies considerably in individual cases both as regards character and intensity, this being due partly to the virulence and localization of the poison and partly to a mixed infection.

Statistics show that at least 50 per cent. of all cases occur during the months of August, September and October, and two-thirds of all cases between the ages of 15 and 30; yet you should be ever mindful of the fact that in the temperate zone it is an endemic disease, affecting those of all ages, the youngest and oldest cases reported being, respectively, aged six months and 75 years.

There is no one early symptom of the disease which is diagnostic, but it is the syndrome, viz., chilly sensations, headaches, lassitudes, inaptitude for work, anorexia, diarrhea, epistaxis, abdominal pain, which come on insidiously and grow progressively worse, which is suggestive. Any one of the above symptoms may, however, so predominate the scene that unless you are a careful examiner you may fail to elicit the other symptoms from the patient, and hence may mistake the condition for one of an acute neurotic,

pulmonic, gastric or nephritic disorder by the predominance of their respective symptoms. During this stage the patient usually meanders about the house, and finally takes to bed.

During the first week after going to bed the most characteristic conditions which will aid you in your diagnosis are noted, viz., the steady rise of fever, the evening record rising a degree to a degree and a half higher each day until reaching  $103-104^{\circ}$  Fahr.; the relative brachycardia, from 100 to 110, with a pulse of full volume, low tension and very often dichrotic, and finally toward the end of the week the enlargement of the spleen, the outcropping of the rose spots, and tympanitis clinch the diagnosis. All during this period the patient usually complains of a cough, bronchitis, headaches, and may even have mental confusions and wandering at night.

During the second week after taking to his bed all the symptoms become aggravated, the fever remains high, the morning remissions are slight, the pulse becomes rapid and loses its dichrotic character, the face looks heavy, and the tongue in severe cases becomes dry and covered with a brownish fur.

In the third week the temperature shows marked morning remissions, and there is a gradual decline in the fever. Diarrhea and meteorism may now occur for the first time, and you also have the coming on of the signs of weakness, viz., loss of flesh, feebleness of the heart and muscular tremors.

With the fourth week convalescence usually begins, the temperature reaches the normal point, the diarrhea stops, the tongue cleans and the desire for food returns.

#### SPECIAL SYMPTOMS AND SERUM DIAGNOSIS.

Rose spots are characteristic hyperemic spots which appear from the seventh to tenth day, and usually first upon the abdomen. They are slightly raised, flattened papules, which can be distinctly felt by the finger, of a rose-red color and disappearing upon pressure. They come out in successive crops, and after persisting for two to three days disappear, occasionally leaving a brownish stain, especially in brunettes. These spots occasionally appear first upon the back and lower portion of front chest wall instead of upon the abdomen, and, indeed, in the past season this has been the rule instead of the exception at this hospital.

*Blood.*—Nearly all cases of typhoid are associated with an anemia, some reaching as low as

1,300,000 R. B. C. In all uncomplicated cases there is a leucopenia, with a relative lymphocytosis. Due to the anemia, the hemoglobin is reduced, but the color index is plus 1. It should also be remembered that typhoid is a bacteremia.

*Gastro-intestinal Symptoms.*—The symptoms of this tract should be considered merely as manifestations of hyperirritability, and hence you may have either constipation, diarrhea, or alternately constipation and diarrhea.

Bronchitis is one of the most frequent of the initial symptoms. Epistaxis precedes typhoid more frequently than any other febrile affection.

*Ehrlich's Diazo Reaction.*—This test has fallen into disuse because of its unreliability, i. e., not all cases of typhoid react, and a positive reaction occurs in miliary tuberculosis, malaria, and occasionally in other conditions associated with high temperatures.

*Widal's Agglutinative Test.*—As regards this test, it should, in the first place, be borne in mind that the formation of agglutinins is a process which proceeds simultaneously with the establishment of immunity, and therefore the reaction rarely develops before a week or 10 days. It is not absolutely diagnostic, as other microbic infections may give the reaction, but these conditions are rare, and in only  $2\frac{1}{2}$  per cent. of cases is it in error, whilst it is present in 90 per cent. of all cases of typhoid infection. This reaction may persist for many years after the disease, and hence the fact of having had typhoid before or having been immunized against it by vaccines should always be taken into consideration. It should also be borne in mind that the reaction is not an index as to the severity of the disease, as you may readily obtain agglutination in mild cases and again secure none in severe cases, or *vice versa*.

*Recovery of Typhoid Bacilli.*—The recovery of typhoid bacilli from the patient's blood or from suspected rose spots is absolutely indicative that the illness is that of typhoid, but this is a procedure not practical for the average physician. The recovery of typhoid bacilli from the feces and urine, a difficult procedure, does not, however, necessarily indicate that the condition is typhoid, as carriers, and even those who have not had the disease, sometimes harbor them in their gall-bladder and kidney.

#### SYMPTOMS OF COMPLICATIONS.

*Hemorrhage.*—From the end of the second to the beginning of the fourth week one should al-

ways be on the alert for hemorrhage, and especially if tympanitis be present. The most characteristic symptoms of it are a sudden drop of six to seven degrees of temperature within a few hours, with a corresponding rise in the pulse and respiratory rates, and the former may even cross the temperature curve. Later blood will appear in the stools, either fresh or tarry, and there is a soft, boggy mass in the abdomen. You should not, however, wait for the blood to appear in the stools before starting treatment, but if the other symptoms above mentioned be present it is best to always presume hemorrhage to be present and immediately institute treatment, for by such a procedure you can do your patient no harm, and in the majority of cases it will later be found by the blood in the stool that hemorrhage has occurred.

*Perforation.*—The symptomatology of this serious complication as described in the various standard textbooks would never lead one to make an early diagnosis of perforation, but would necessitate the oncoming of a peritonitis before recognition. This was first pointed out by Dr. Bagley of this city. Perforation usually first manifests itself by the sudden oncoming of sharp lancinating pains over McBurney's point, extreme tenderness over the same area, and muscular rigidity due to a spasm of the rectus muscle. The occurrence of these three cardinal signs without any other reactions would warrant an exploratory laparotomy, as typhoids, relatively, bear operations exceedingly well. You should never wait for the Hippocratic facies, thready pulse, vomiting, leucocytosis, shallow respirations, etc.—as these are symptoms of peritonitis, and after their development the chances of the patient are markedly lessened. From the above it is seen that it is absolutely essential that everyone treating a case of typhoid should become perfectly familiar with his patient's abdomen, and especially so if hemorrhage has occurred, as 20 per cent. of all perforations are preceded by hemorrhage.

*The Symptoms of Typhoid in Children.*—Typhoid runs a much milder course in children, and the severity of the symptoms bears a direct relationship to the age of the patient, *i. e.*, the younger the patient the less severe the symptoms and course of the disease. There is frequently a sudden onset, with fever, prostration and vomiting. Chills and epistaxis are comparatively rare. There

may be absolutely nothing characteristic of the alimentary tract or there may be mild constipation or diarrhea. The skin eruption is less abundant, less constant and less characteristic than in adults. The initial rise in the temperature curve is more rapid, the remittant character during the second week is less marked, and the average duration is shorter than in adults. The pulse is relatively rapid, and dicrotism rare as compared with adults. As a rule, the nervous manifestations are much more prominent than the intestinal symptoms, but the extreme neurotic disorders are rarely seen, headaches and mild delirium at night being the chief manifestations. Occasionally in severe cases the nervous symptoms may simulate meningitis.

*Résumé.*—From the foregoing it is seen that the salient points upon which a conclusive diagnosis of typhoid may be established are:

1. The demonstration of the specific causal agent, the typhoid bacilli, in the body of the patient.
2. By the demonstration of the changes in the blood and tissue fluids giving them specific agglutinative properties, and
3. The recognition of a symptom-complex, viz., the temperature curves, the intestinal symptoms, the characteristic rash, the enlarged spleen and other less prominent symptoms; characteristic of the reaction of the organism to the typhoid bacillus.

The Eta Chapter of the Phi Sigma Kappa gave an "At Home" to their friends at their new home, 816 Park avenue, February 9, 1912.

Extracts from some letters:

"With my best wishes for a successful year."—*George H. Stuart, M.D., class of 1899, of Ottoman, Va.*

"Can't afford to be without THE BULLETIN, as it keeps me in touch with what is going on at the old University. I find something in every number that is both interesting and instructive. I've enjoyed Prof. Winslow's 'See America First'; also Prof. Ashby's 'A Hurried Trip Through Europe.'"—*W. C. Curry, M.D., class of 1881, Flemington, N. J.*

"I enjoy reading THE BULLETIN very much, and am always glad when it comes to my desk."—*T. A. Matthews, M.D., class of 1890, Castalia, North Carolina.*



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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MARCH 15, 1912.

## RETROSPECT AND PROSPECT.

In 1893 the Medical School of the University of Maryland had been 86 years in existence, and there was not one cent of endowment. Some years previously a futile attempt was made to secure funds, to the extent of appointing a committee, whose names were published in the annual announcement, and there the effort ceased. In 1893 Dr. Eugene F. Cordell, then and now an enthusiastic and loyal alumnus, had a clear vision of the urgent necessity for an endowment, and sounded a clarion note of warning and a ringing appeal for aid. This appeal fell upon deaf ears and on stony hearts. In 1897, at a meeting of the alumni held in Chemical Hall in the Medical School, Dr. Cordell again sounded the alarm and called for subscriptions. Dr. Randolph Winslow of the class of 1873, rose and said he wished to be the first to contribute to a fund for the endowment of the Medical School, and a number of others also pledged their support. The fund increased very slowly, but during the year 1907, as a result of the centennial celebration of the founding of the University, a considerable increment was secured. Funds were established for various purposes, but practically for two great objects — (1) the endowment of the Medical School, (2) an endowment fund for general University purposes. In the nearly five years that have elapsed since the centennial celebration these funds have gradually grown, mostly through the unselfish efforts of Dr. Cordell, and the total amount of the funds now in

hand is considerably more than \$40,000. This is not a large sum, but it is a long way better than nothing, and it is increasing steadily. The Faculty of Physic fund, which can be applied to the chair of pathology, at this writing amounts to \$16,882 in hand. The Robinson bequest has been paid and is in the hands of the trustees of the Endowment Fund, though a generous deduction was made by the State for the collateral inheritance tax. We are therefore making progress and we must not be discouraged, but must redouble our efforts, and look forward.

## SECOND CALL FOR DINNER.

Twelve months have rolled around since we first began the effort to raise \$100,000 for the endowment of the department of pathology. The work was undertaken because we saw an imperative need, and because there was no one else who seemed able or willing to make the effort. It is an effort that is not only distasteful to the writer, but one for which he feels his unfitness. He has expended his energies mostly upon the graduates of the Medical School, and while the results have not been in proportion to the effort, he is profoundly thankful to the considerable number who have responded to the call. A widespread interest has been aroused, and we believe there are many others who, as time and opportunity present, will contribute to the cause. Since the appeal was first made, in March, 1911, conditions have greatly changed, and we are now confronted with the necessity of supplying six paid laboratory instructors, who must devote their entire time to teaching and research. A school will not be in good standing that does not comply with this requirement, and its graduates will not be allowed to practise in New York. The Council on Medical Education of the American Medical Association and the Association of American Medical Colleges view askance schools that do not have their scientific chairs filled by full-time, salaried instructors. The University of Maryland must not lag in the rear, but must keep in the advance. This will still further strain our resources, and make it still more imperative that we receive assistance from our friends. Many of us in our travels who may have neglected to respond to the call to dinner, or who may have been crowded out by others more vigilant than our-

selves, know how pleasant is the voice of the dusky herald as he passes through the train and cries "Second call for dinner!" We also are now passing through the train, and we loudly cry, "Second call for dinner!"

The subscriptions to March 1, 1912, are as follows:

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Dr. Herbert E. Zepp, 1904.....	25 00
Dr. Robert Bay, 1905.....	100 00
Dr. B. F. Tefft, 1905.....	100 00
Dr. Edward L. Bowlus, 1906.....	5 00
Dr. Joseph A. Devlin, 1906.....	10 00
Dr. W. F. Sowers, 1906.....	25 00
Dr. R. W. Crawford, 1906.....	25 00
Dr. Matthew L. Freilinger, 1906.....	10 00
Dr. Leo Karlinsky, 1906.....	20 00
Dr. J. F. Hawkins, 1906.....	25 00
Dr. Richard C. Hume, 1906.....	10 00
Dr. Frank S. Lynn, 1907.....	25 00
Dr. T. H. Legg, 1907.....	5 00
Dr. Albert H. Carroll, 1907.....	25 00
Dr. Edgar S. Perkins, 1907.....	25 00
Dr. W. Cuthbert Lyon, 1907.....	5 00
Dr. Thomas H. Phillips, 1908.....	25 00
Dr. J. N. Osborn, 1909.....	5 00
Dr. E. H. Kloman, 1910.....	25 00
Terra Mariae, 1911.....	3 50
Latin-American Club, 1912.....	25 00

Total.....\$9630 50  
 Additions for the month, \$185.

## ITEMS

Profs. Randolph Winslow and R. Dorsey Coale attended the recent meeting of the Association of American Medical Colleges held at Chicago. Dr. Winslow was elected a member of the Executive Council of the association for the coming two years.

Dr. A. W. Valentine, class of 1904, of 606 North Carolina avenue S. E., Washington, D. C., writes as follows:

"Enclosed find check in payment of bill. I do hope that everything is progressing satisfactorily

in putting the University of Maryland upon an everlasting foundation. Not much enthusiasm over here; wish you could send a few spellbinders over to wake 'em up."

Prof. R. Dorsey Coale is in receipt of the following letter:

"My Dear Dean—It gives me great pleasure to convey to you the wishes of the 'Latin-American Club' for the rapid and complete success of the noble work already begun for the endowment of the pathological chair of the University.

"This work will undoubtedly place our institution on an equal footing with the most modern universities of today. Toward this end the members of this club send their small contribution of \$25, and hope in the future to be able to do more for our Alma Mater, conjointly and individually.

"Sincerely yours,

"ANDREAS G. MARTIN,

"Class of 1912."

We would be pleased if some of our readers could give us the addresses of the following alumni: Dr. Howard Steele Holloway, class of 1903, who was for a time in Jacksonville, Fla.; Dr. Roscoe C. Carnall, class of 1905, formerly located in Waverly Mills, S. C.; Dr. Alexander R. Mackenzie, class of 1910, who was at Sparrows Point and later at Blakeley, W. Va.; Dr. Alvin Clay McCall, class of 1910, formerly of Folkstone, N. C.; Dr. Eugene B. Howle, class of 1910, of North Carolina; Dr. Max Joseph Fiery, class of 1910, and Dr. Frank Paul Fiery of the same class; Dr. Lafayette Lake, class of 1906, recently located in Jackson, La.

Dr. Albert J. Underhill, of the Walbert Apartments, assistant in the genito-urinary department at the University of Maryland, begs to announce that in future he will limit his practice to the treatment of genito-urinary diseases.

Dr. Charles I. Stottemyer, class of 1892, is located at Hagerstown, Ind.

Dr. Robert Parke Bay, class of 1905, has been appointed visiting surgeon to Mount Street Hospital, Baltimore; Dr. E. H. Kloman, class of 1910, visiting gynecologist; Dr. Hoagland Cook Davis,

class of 1902, visiting laryngologist; Dr. C. W. Mitchell, class of 1881, visiting physician; Dr. Claude C. Smink, class of 1909, visiting physician.

Report of cases entering the dispensary departments of the University Hospital for January, 1912:

## DISPENSARY.

	New.	Old.	Total.
Surgical .....	157	399	456
Medical .....	109	236	345
Genito-urinary .....	56	242	298
Eye and ear.....	54	78	132
Tuberculosis .....	39	56	95
Nose and throat.....	36	63	99
Children .....	28	52	80
Stomach .....	26	52	78
Nervous .....	12	84	96
Gynecological .....	46	79	125
Skin .....	26	36	62
Orthopedic .....	2	4	6
Rectal .....	3	14	17
Total .....	594	1395	1889
X-ray, 60 cases.		Laboratory.	

Dr. Dempsey William Snuffer, class of 1906, of Beckley, W. Va., writes: "I'm always glad to pay for THE BULLETIN, as well as to receive it. It keeps me well informed as to the workings of the University."

Dr. Louis Winfield Kohn, class of 1910, is located at 429 Wyoming avenue, Scranton, Pa.

Dr. Frank Oldham Miller, class of 1902, of Ellicott City, Md., writes that "THE BULLETIN is my only means of keeping track of former classmates and their whereabouts."

Dr. Thomas B. Owings, class of 1852, of Ellicott City, Md., one of the oldest alumni of the University, has retired from active practice during the past year.

Dr. William Emrich, class of 1902, is physician to the Maderia Mamore Railroad at Porto Bello, 1500 miles from the mouth of the Amazon, Brazil.

Miss Emily L. Ely, University Hospital Training School for Nurses, class of 1909, and Miss

Elizabeth Getzendanner, of the same class, are both nursing in Jacksonville, Fla.

Dr. James Madison Lynch, class of 1904, announces that on January 22, 1912, he opened offices at 6 and 8 Dehumor Building, Asheville, N. C., for the practice of general surgery.

Dr. Oakey S. Gribble, class of 1905, was a recent visitor to the University Hospital. Dr. Gribble has been wintering in the South.

Dr. Charles Augustus Overman, class of 1903, has forsaken medicine to enter upon the study of law, and is now an intermediate in the law school of the University of Maryland.

Dr. Compton Riely, class of 1897, has been appointed a member of the visiting staff to the Church Home and Infirmary. Dr. Riely specializes in orthopedic surgery.

Dr. Edward E. Lamkin, class of 1898, who has been confined to the University Hospital with a fractured arm, which he had plated, has sufficiently recovered to return home.

Miss Anna S. Grubbs, University Hospital Training School for Nurses, class of 1911, has joined the staff of visiting nurses, and will work in the Hampden District.

Dr. John Wilson MacConnell, class of 1907, of Davidson, N. C., writes as follows:

"January 25, 1912.

"I take pleasure in paying my subscription to THE BULLETIN, for I would not like to miss a number. It keeps me in touch with the Maryland men as no other publication could. All goes well with us here. As you know, I am physician to Davidson College and *locum tenens* professor of biology, and have been for the past three years. I am hoping that a regular professor will be elected soon so that I may give all my time to my medical work. A good many of our graduates go to the University of Maryland. In all the departments now at Maryland we have over a dozen men from Davidson, and at Hopkins we have eight in the Medical School. I am anxious to see Maryland raise the standard to two years of col-

lege work as a minimum entrance requirement. The course as now given is all right, but with advanced entrance requirements the students could cover more ground and assimilate more rapidly the teachings of the professors. No school has a more able faculty than that at Maryland now, and though we often say 'there were giants in those days,' it can be safely said also that 'thou dost not inquire wisely when thou sayest that former times were better than these,' for Maryland is better today than ever and has greater promise for a glorious future.

"I would like to get in touch with some of the alumni who will go abroad this summer. I want to visit the European clinics, and would much prefer having a companion.

"With all good wishes, I am,

"Sincerely,

"JOHN W. MACCONNELL."

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Dr. Joseph Blum, class of 1885, has retired from a practice covering a period of 27 years, and will make his future home in New York, after a residence of 50 years in Baltimore.

Dr. Blum leaves Baltimore with many regrets, conspicuous among these his severance of ties with the members of the medical profession, but these regrets will be appeased by recollections of the most pleasant relations that have always obtained between his medical friends and himself.

Dr. Blum takes advantage of these columns in bidding farewell to the members of the medical profession of this city.

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The Randolph Winslow Surgical Society has been formed by 35 University students, 23 seniors and 12 juniors, the object being to promote closer relationship among the students of the medical department. The organization has the worthy aim of promoting in the hearts of its members a deep sensibility of their debt to their Alma Mater.

The officers, all members of the senior class, are: Henderson Irwin, president; H. A. Bishop, vice-president; Michael Vinciguerra, secretary; E. P. Kolb, treasurer, and R. E. Abell, historian.

The honorary members are Professors Randolph Winslow, J. Holmes Smith, Arthur M. Shipley, Frank Martin, St. Clair Spruil, J. W. Holland and Nathan Winslow; Drs. W. J. Cole-

man, Robert P. Bay, Frank S. Lynn, Frank J. Kirby, Page Edmunds, J. Holmes Smith, Jr., and J. A. Tompkins.

The movement which resulted in the formation of the society was started by Mr. Irwin, its first president. On the committee that assisted him in formulating plans for its organization were Messrs. Abell, Bishop, Cochran, Sellers and Tullidge.

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Dr. B. Merrill Hopkinson, class of 1885, has been appointed for the twenty-third consecutive year president of the Baltimore Athletic Club.

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Dr. J. Dougal Bissell, class of 1888, of 365 W. 81st street, New York, has been elected professor and surgeon to the Woman's Hospital in New York. He was formerly assistant to Professor Cleveland, and was advanced upon the retirement of Dr. Bache Emmett.

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The schedule for the University of Maryland baseball team, C. Harry Stevens, manager, for the coming season is as follows:

March 20—Navy, at Annapolis.

March 27—Washington College, at Chestertown.

March 30—Western Maryland College, at Westminster.

April 2—Mount St. Mary's College, at Emmitsburg, Md.

April 6—Dickinson College, at Carlisle, Pa.

April 10—Mount St. Joseph's College, at Baltimore.

April 13—St. John's College, at Annapolis.

April 17—Rock Hill College, at Baltimore.

April 20—Randolph-Macon College, at Ashland, Va.

April 22—Fredericksburg College, at Fredericksburg, Va.

April 27—Pending.

April 30—Pennsylvania State College, at State College, Pa.

May 1—Pending with Ursinus College.

May 4—Baltimore Medical College, at Baltimore.

May 7—Seton Hall College, at South Orange, N. J.

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Dr. Baird U. Brooks, class of 1905, of West Durham, N. C., is a patient at the Union Prot-

estant Infirmary, where he will be operated on by Dr. John M. T. Finney.

Dr. J. Righton Robertson, class of 1910, announces the opening of his office in the Miller Walker Building, Augusta, Ga., March 1, 1912.

The basketball team has closed its season. Following is an account of receipts and expenditures for the season:

#### *Expenditures.*

Incidental expenses.....	\$38 32
Printing—posters, etc.....	9 00
Equipment, suits, etc.....	70 00
Expenses of team to other schools.....	287 39
Total expenses.....	\$404 71

#### *Receipts.*

From games:	
From Maryland Medical College.....	\$10 00
From Columbia University.....	50 00
From City College of New York.....	55 00
From Maryland Medical College.....	9 00
From Loyola College.....	10 50
From Catholic University game.....	20 00
From Georgetown game.....	20 00
From Swarthmore game.....	84
From Mt. St. Mary's game.....	5 65
From Mt. St. Joseph's game.....	4 85
Refund traveling expenses.....	140 43
Total receipts.....	\$326 27
Cost for year.....	\$78 44

The theater benefit given on February 7 at the New Academy of Music for the benefit of the track team was fairly successful, though as yet about \$70 worth of tickets are out for which no returns have been made to the treasurer of the Alumni Athletic Association. The expenses were as follows:

Printing and postage of tickets.....	\$27 91
Paid Academy of Music.....	158 75
Total.....	\$186 66
Received from theater tickets.....	\$249 50

Part of the sum received, however, was donated by persons who did not use the theater tickets.

## UNDERGRADUATES' NOTES

*Under the Supervision of E. A. Looper.*

The Athletic Association is certainly to be commended upon the progress it has made in the short time since its organization at the beginning of the school year. The students are becoming more and more interested in its maintenance, and display much enthusiasm at each athletic meet. It seems unnecessary to prophesy that this will undoubtedly be the most potent factor in stimulating greater class spirit among the students.

\* \* \*

An interesting field meet was held January 27 between the University and the Cross Country Club in the Fifth Regiment Armory, in which the University boys made a very creditable showing, taking off a number of the honors. Timanus, of the sophomore class, proved himself quite an athlete, obtaining the highest number of individual points, winning third place in the 50-yard hurdle and second place in the shot put. Porter and Shriver of the freshman class also won honors, Shriver winning the 16-pound shot put, and Porter second place in the pole vault.

\* \* \*

It has been proven that the University contains quite a number of good athletes who are only handicapped by lack of proper training, which they have been unable to obtain during the year on account of the proper facilities and the lack of time. However, they have always shown themselves to be good sportsmen, and have sustained the reputation of always playing fair and honest games.

\* \* \*

A benefit performance was given at the Academy Wednesday, February 7, to increase the athletic fund. Most of the professors and students at the University attended. Quite a nice sum was realized, which will greatly enlarge the equipment for the coming year.

\* \* \*

Quite a number of the senior students of the University intend taking the competitive examinations at the various hospitals in the city. The University men always show up well in these examinations, the class of 1911 being represented by internes in the principal hospitals of the city, having five of its members at Bayview, one at St. Joseph's, one at the Church Home, two at the

Hebrew Hospital, one at Eudowood and one at Kernan's, besides the appointments at the University Hospital.

\* \* \*

The senior students have been greatly interested in the practical clinics given at the different hospitals under the direction of professors of the various departments. The class is divided into sections to meet Dr. Hiram Woods at the Presbyterian Eye and Ear Hospital on diseases of the eye and ear, Dr. Irving Spear at Bayview Insane Asylum on mental diseases, Dr. R. Tunstall Taylor at Kernan's Hospital for Crippled Children on orthopedic surgery and Dr. John R. Winslow in the dispensary of the University Hospital on diseases of the nose and throat.

### FRATERNITIES.

The members of the Chi Teta Chi Fraternity entertained with an informal smoker at their Chapter House Saturday evening, January 27.

\* \* \*

The Nu Sigma Nu Fraternity gave their annual fraternity dance at Albaugh's, Wednesday, January 31.

\* \* \*

On Friday evening, February 9, the Phi Sigma Kappa Fraternity entertained with a tea party, which was followed by a dance, at their Chapter House on Park avenue.

### BIRTHS

Mr. and Mrs. Joseph Wright of Easton, Md., are receiving congratulations upon the birth of a son. Mrs. Wright was formerly Miss Ann Elizabeth Chapman, University Hospital Training School for Nurses, class of 1906.

On February 5, 1912, Addison Clarke, son of Dr. and Mrs. Sydenham Rush Clarke. Dr. Clarke is a member of the class of 1905.

### MARRIAGES

Dr. Napoleon Bryan Stewart, class of 1910, was married to Miss Edna May Revell in Trenton, N. J., November 29, 1911. The marriage was announced at the annual banquet of the Phi Sigma Kappa Fraternity and came as a great surprise to Dr. Stewart's friends. The couple, aided by Dr. Ralph C. P. Truitt, class of 1910, were

married by the Mayor of Trenton, the parents of both having full knowledge of the marriage and plans. Dr. Stewart is the son of the late Dr. Stewart of Delta, Pa., and Mrs. Stewart is the daughter of Mr. and Mrs. Frank S. Revell of Anne Arundel county.

Dr. Vernon Francis Kelly, class of 1904, of 3705 Falls road, Baltimore, was married to Miss Laura E. H. Spangler, daughter of Mr. Charles W. Spangler at noon Thursday, March 7, 1912, at the residence of the bride, Liberty Heights avenue, Forest Park, the Rev. Dr. George R. Grose of Grace M. E. Church, Baltimore, performing the ceremony. The bride wore a blue broadcloth traveling suit, with hat to match, and a corsage bouquet of violets and orchids. The house was decorated with palms and pink roses. The couple, after a trip North, will reside at 3705 Falls road.

Dr. Arthur Edward Ewens, class of 1904, of Atlantic City, N. J., was married to Miss Florence Lane Johnson, daughter of Mr. and Mrs. Edward Stockton Johnson, of Atlantic City, on Tuesday, February 27, 1912. The couple will reside at the Le Grand Apartments. Dr. Ewens was well known at the University and was very popular with his class. He was so unfortunate as to lose his mother, Mrs. Henrietta Hill Ewens, who died in Baltimore during the latter part of January.

### DEATHS

Dr. Gilbert C. Greenway, class of 1868, died at his home, 118 Wilberforce avenue, Hot Springs, Arkansas, January 19, 1912, aged 70 years. Dr. Greenway was a native of Virginia.

Dr. James S. Lovell Muscey, class of 1891, of Pearisburg, Va., died at Pembroke, Va., December 29, 1911, as the result of a carriage accident, aged 45 years.

Dr. Thomas Robert Dougher, class of 1909, of Avoca, Pa., a member of the staff of Pittston Hospital, died at his home February 16, 1912, from meningitis following an attack of pneumonia, aged 64 years.

Dr. George Edward Hurst Harmon, U. S. N.

(retired), class of 1872, died at the residence of his aunts, Mrs. M. E. Harmon and Miss Sarah A. Hurst, at Cambridge, Md., March 5, 1912, of a complication of diseases. Dr. Harmon was the son of the late Dr. George and Mrs. Mary Elizabeth Hurst Harmon. After graduation Dr. Harmon practiced medicine for a short time, then entered the medical corps of the Navy, filling several important posts. At the time of his retirement, in 1910, Dr. Harmon was in command of the Navy Medical School Hospital, Washington, D. C. Besides his aunts, Dr. Harmon is survived by a sister and an uncle.

Dr. Norton Royce Hotchkiss, class of 1891, died at his residence in New Haven, Conn., January 30, 1912, of leukemia, from which he had suffered for years. Dr. Hotchkiss was 41 years of age. He was born at Fort Mill, S. C., August 23, 1870, and was educated in public schools, later studying medicine at the South Carolina Medical College and the University of Maryland. He settled in New Haven the year of his graduation, and had been most successful.

Dr. Hotchkiss was a member of the American Medical Association and the Association of Military Surgeons of the United States, and president of the New Haven Medical Association. He served under Governor Woodruff (1897) as surgeon-general of the State. He was a director of the Elm City Hospital and an attending surgeon at St. Raphael's Hospital. Dr. Hotchkiss was interested in fraternal organizations, and at the time of his death was a thirty-second degree Mason. He is survived by his widow, formerly Miss Lucy E. Belk of Portsmouth, Va., and three children.

Dr. Peter H. Latham, class of 1876, died at his home in Weatherly, Pa., January 23, from diabetes, aged 62. Dr. Latham was coroner of Carbon county, Pennsylvania, and for many years visiting physician at the Laurytown Almshouse and local surgeon for the Lehigh Valley Railroad.

Dr. Mathias Adolph Edward Borek, class of 1863, died at his home in St. Louis January 20, 1912, from senile debility, aged 77 years. Dr. Borek was an acting assistant surgeon in the United States Army, and later assistant surgeon of the Tenth Maryland Volunteer Infantry and

Third Maryland Volunteer Cavalry during the Civil War. He took a course and graduated at Washington University, St. Louis, Mo., in 1874, and was professor of surgery in the St. Louis College for Medical Practitioners, of which he was one of the founders.

Dr. Nathan D. Tobey, class of 1863, died at his home in Vaughan, N. M., January 19, 1912, aged 74 years. Dr. Tobey was a member of the Golden Belt Medical Society and formerly president of the Salina (Kans.) Medical Association. Dr. Tobey practiced medicine in Salina, Kans., for 25 years. For three years he was editor of the *Salina Herald*.

Dr. John L. Blair, class of 1868, died at his home in Mercersburg, Pa., December 31, 1912, aged 66 years.

Dr. John Fletcher Powell, class of 1853, of 304 West Lanvale street, Baltimore, died at his home February 15, 1912, from senile debility. Dr. Powell was born in Baltimore, and received his early education in private schools and at Phillips' Academy, Andover, Mass.

During the yellow-fever epidemic in Norfolk and Portsmouth in 1855, in which 31 physicians, natives and volunteers died, Dr. Powell was appointed by this city as one of the health officers for the Old Bay Line steamers. For three months he traveled on the steamers, exercising quarantine supervision.

He spent one-third of the time ashore aiding the sick and studying the disease. As physician of the Baltimore City Jail Dr. Powell during the Civil War had more than 900 Confederate prisoners under his care there. For more than half a century he was a member of Concordia Lodge of Masons. He was also a member for 55 years of the Medical and Chirurgical Faculty of Maryland.

He is survived by a widow, who was Miss Alice A. Tilyard, and five children.

Dr. Julius Levin, class of 1905, formerly of Chicago, was found dead in his apartments in Johnstown, Pa., February 12, 1912, from accidental asphyxiation by carbon monoxid, aged 32 years.



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No. 2

## PRACTICAL EXPERIENCE WITH SPINAL ANESTHESIA.\*

By LOUIS WINFIELD KOHN, M.D., 1910,  
*Interne State Hospital, March, 1911.*

By spinal, subarachnoid or lumbar anesthesia is understood a method of rendering portions of the animal organism insensible by the injection of local anesthetics into the subarachnoid space of the spinal canal.

Some of the anesthetics employed for this purpose are cocaine, tropococaine, novocaine and stovaine. During my connection with this hospital it has been my fortune to witness, and at the same time study, this mode of anesthetization, the immediate effects and results produced. What knowledge I have acquired in this type of anesthesia has been gained during my service under the staff surgeon, Dr. E. G. Roos, who has employed this means of anesthetization in conjunction with 80 or more operative cases.

I will now endeavor to relate some of our practical experiences with this form of anesthesia, hoping at the same time to make such as interesting as possible. The anesthetic of choice with Dr. Roos is stovaine, because of its comparative harmlessness if properly employed. The solution employed is from Billon of Paris, and contains 4 per cent. stovaine. The dose varies according to the condition of the individuals and their apparent ages. The dose commonly employed by Dr. Roos is from 4 to 6 cgm., although as low as  $1\frac{1}{2}$  cgm. and as high as 7 cgm. have been used. From our experiences here certain operations have been performed where either the anesthesia was incomplete or not of such lasting effect as to allow completion of operation. In such a case a general anesthetic has been resorted to. To overcome any such occurrence the patient is always

ordered to be prepared for general anesthesia in conjunction with other preparations.

The material required for the injection of the anesthetic is as follows: First, a wire probe with a piece of sterile cotton wound on one end. This is dipped into carbolic-acid solution (95 per cent.), and the spot where the needle is to be introduced is touched with this carbolic applicator. This spot is thus rendered antiseptic and somewhat anesthetic. This carbolic spot is allowed to evaporate to dryness before puncturing, thus insuring no entrance of carbolic acid into the spinal canal. Second, a cannula, long and thin, beveled at its pointy end expressly made for this purpose, hollow and of small caliber throughout its length. Third, a mandrel or puncturing rod, which fits into the cannula and is withdrawn as soon as you have determined that the subarachnoid space is near. Fourth, a glass syringe properly graduated. The one employed by Dr. Roos is of the Luer type and of 2 c. c. volume. Fifth, the stovaine solution, which comes in vials of 2 c. c. volume; each c. c. of the stovaine solution contains 4 cgm. of the active principle stovaine. All of this material should be kept separate and away from the other instruments. They should be sterilized by boiling in distilled water.

The preparation of the patient will now be discussed:—The nurse is instructed to prepare the patient for operation, for general anesthesia and for spinal anesthesia. In preparing for operation the proposed site of operation is thoroughly cleansed in accordance with the hospital method, viz., tincture of green soap and water, followed successively with alcohol, ether and bichloride of mercury solution (1-5000). Then aseptic dressings are applied. By preparation for general anesthesia is meant the withdrawal of all nourishment for a period of at least 12 hours before operation, the administration of calomel, grs. 2, in divided doses of gr.  $\frac{1}{4}$  every quarter hour, begun at least 18 hours before operation, and the administration of  $MgSO_4$  sol., 1 oz., an hour after

\*Read before Lackawanna County Medical Society November 28, 1911, at Scranton, Pa.

all calomel has been given. A simple enema is also given at least six hours before operation for the purpose of evacuating the lower bowel and avoiding unnecessary defecation during the operative procedure. We next resort to the preparation for spinal anesthesia, and this is accomplished by thoroughly cleansing and aseptically preparing the entire back of the patient (between parallel lines, one running through the seventh cervical spinous process above and the other through the lower border of the sacrum below as well as between the midaxillary lines on the sides) as for operation described above. It has also been a custom in the majority of our cases to administer two hours before operation by hypodermic injection morphia sulphate, gr.  $\frac{1}{6}$ , and hyoscine hydrobromide, gr. 1-100, for the purpose of slightly depressing the cerebral cortex, thus bringing about a certain degree of hypnosis, which is of advantage in that it materially aids in the production of a quicker anesthetic effect as well as the avoidance of any ill psychic influences. The patient is ordered to the operating-room at a stated time. The surgeon and his assistants prepare for the operation and the anesthetic administration. Thorough asepsis on the part of the surgeon, his assistants and nurses are insisted upon and rigidly observed. The instruments are all sterilized by boiling in distilled water.

*Preparation for the Administration of the Anesthetic.*—The patient is placed upon the operating table, but instructed to sit up across the width of the table with the buttocks resting near the extreme edge of the one lengthy side, whilst the legs will hang from the knees down on the other lengthy side of the table. The patient is also instructed to fold the arms and bow the back so as to bring about a strong lumbar flexion. This flexion increases the height of each interspinous space and facilitates the proper introduction of the needle. An assistant at the same time, by passing an arm from behind forward around the patient's neck, greatly supports and steadies the patient. The dressings (as a result of previous preparation) are next removed and the back exposed. The approximate site for injection is again antiseptized with alcohol and bichloride of mercury solution, followed by washing with sterile water and then dried. A sterile towel is then employed, the upper edge of which is applied crosswise over the back so as to coincide with the upper border of the iliac crests. We now know

that the interspinous depression found near the junction of this towel with the spinal column is between the fourth and fifth lumbar vertebrae. Having once found this intervertebral space, we next ascertain the point for injection. This point is about 1 mm. to the right or left of the midline. Dr. Roos usually enters between the second and third lumbar vertebrae, although he has injected into all the interspaces between the twelfth dorsal and fourth lumbar vertebrae. In operations upon the gall-bladder or stomach he has injected between the twelfth dorsal and first lumbar vertebrae. These points are easily located upon inspection and palpation.

*The Mode of Injection.*—Having located the point for entrance, it is touched up with the carbolic-acid applicator. As soon as this carbolic spot has evaporated to dryness the top of the vial (containing the stovaine) is next broken and the glass syringe filled with stovaine. The cannula (with the puncturing rod or mandrel within its hollow viscus) is then introduced directly forward at a right angle to the skin. As soon as you feel that resistance is overcome you have pierced the interspinous ligament, and now it behooves you to draw out the puncturing rod. If you should have entered the subarachnoid space spinal fluid will drip out of the cannula; but if not, then push the cannula slightly forward, and after having overcome a slight resistance, due to the dura mater and arachnoid membranes, spinal fluid will begin to drip forth. An assistant is then instructed, after having allowed a few c. c. of spinal fluid to drip out, to place a finger over the mouth of the cannula. Then the surgeon arranges his dose in the glass syringe and connects the syringe to the mouth of the cannula (at the same time steadying the cannula). He then draws out some spinal fluid so as to dilute the stovaine solution, and then injects the entire contents of the syringe into the canal. A piece of aseptic gauze is placed over the point of injection as soon as the cannula is withdrawn. The patient is then slowly placed upon the back and a pillow is placed under the head.

While waiting for anesthesia to appear all preparations for operation are being completed. A sterile sheet is also interposed between the head and body, so as to cut off from the patient any possible view of the operation. The ears are stuffed with cotton, so as to avoid hearing the clanging of instruments, verbal remarks, etc.

The eyes are covered with a towel, so as to cut off from view anything of occurrence in the operating-room that may have a depressing effect upon the patient. A small pledget of cotton (well spread out) is stuck on to the tip of the nose, overhanging the anterior nares. This piece of cotton will serve as a safeguard to the respirations, indicating inspiration and expiration by its up and down movement, as well as the nature of the respirations, whether shallow or deep and whether diaphragmatic or due only to the accessory muscles. As soon as anesthesia is recognized the operation is begun.

In some cases the desired anesthesia comes on immediately after injection. In other cases it may be necessary to raise the head end of the table so as to hasten on the anesthesia. This is due to the fact that the stovaine solution is of a lower specific gravity than the cerebro-spinal fluid, and just as soon as the head end of the table is elevated, just so soon does the spinal or heavier fluid buoy the stovaine or lighter fluid upward, and in consequence we have our quicker anesthetic effect. At times, again, when we have a sudden too profound anesthesia as well as hypnosis, we can lower the head end of the table, thus causing the stovaine to be buoyed in the opposite direction, viz., toward the lower end of the spinal canal. The result is that the anesthetic influence will be confined to the lower spinal centers only. In the majority of our cases the anesthetic influence made itself manifest during a period varying from one to four minutes. Four minutes were usually given as the allotted time for the production of anesthesia to its full extent. In order to know whether anesthesia has occurred one must compare the sensibility of a place outside of the anesthetic zone with that of a place where anesthesia is expected. This is done by pinching. If a non-anesthetized area is pinched, the patient will give vent to an expression of pain, or, if the countenance is watched, will wince. On the other hand, by pinching the tissues below the level of injection, viz., perineum, genitals, thighs, etc., they will seem to have lost a certain degree of sensibility. The anesthesia seems to extend from below upward as high as the umbilicus, and often times higher. Cases were noted where upon pinching the anterior surface of the chest as high as the second rib no sensibility was experienced. Within four minutes, as stated above, complete anesthesia is usually encountered. The senses of pain, touch and posture have disap-

peared, and instead the patient only experiences a feeling of numbness in the legs. Together with this, motor paralysis has occurred in the majority of cases. The patient could not move the limbs; reflexes were abolished and the characteristic ankle-drop was apparent—in general, a picture of a flaccid paralysis. Then, again, there were cases where insensibility was most prominent and motor paralysis not so apparent. Instead, only a generalized weakness occurred, nevertheless concomitant with thorough muscular relaxation. The efficiency of our anesthesia was easily demonstrated upon stretching the sphincter-ani muscles and dilating the cervix uteri. The abdominal muscles, as well as the intestinal musculature, in nearly all of our cases underwent thorough relaxation. The patients absolutely have no feeling below the point of injection, and the limbs appear to them as dead. We have had certain patients upon whom, after waiting for 15 minutes, the stovaine produced no appreciative anesthetic effect. In these cases chloroform anesthesia was resorted to, and it is surprising to know how small an amount of chloroform was required throughout the operation. It also appeared in the majority of these cases to Dr. Roos and those present that extraordinary excellent muscular relaxation occurred. In certain cases where numerous operations were performed upon the same person, and where the effect of the spinal anesthetic wore off, chloroform was resorted to and a very small amount was required in each case. The effect of the stovaine in our cases lasted no less than one hour; on the other hand, the effects wore off in periods varying from one to five hours.

During the operation an assistant remains at the head of the table. He encourages the patient, watches the pulse, respirations and general appearance of the patient, as well as complications should they arise. If the condition of the patient permits, water or lemonade may be given to quench thirst. In one case of a man operated upon for hemorrhoids there was a great desire for smoking. His wish was gratified by the presentation of a lighted cigar, which the patient enjoyed throughout the operation, none the worse for his experience. His last words upon leaving the hospital were: "Isn't it great stuff?" In another case of a young woman, upon whom a bilateral salpingectomy and appendectomy had been performed, it was hardly possible just after the operation to convince her that she had been oper-

ated upon, although she remembered the operating-room, with its other attending incidents that day. It is nevertheless true that in some cases the senses are more or less obtunded, whilst in others no such effect is at all noted.

During the anesthesia it has occurred at times that the patient became nauseated and vomited. By lowering the patient's head somewhat this nausea has been overcome. Aromatic spirits of ammonia has also been efficiently employed for this purpose. At times also the patient turns pale and perspires profusely, while the pulse occasionally also, as in general anesthesia, loses some of its better characteristics, and for this purpose such stimulation as is found necessary is employed. No other complications or sequelae of account occurred in any of our cases, but, on the contrary, I dare say, nearly every case recovered with remarkable rapidity.

It was plainly seen that nearly every case enjoyed a more speedy immediate recovery than those operated upon under general anesthesia. The patients were not so depressed just after operation as were the other cases. There was no nausea or vomiting after operation. What did prevail in certain cases for a few hours was that dead feeling in the legs, which gradually disappeared. The patients were immediately put on liquid or soft diet, as was consistent with the case.

We have tried this form of anesthesia on an excellent variety of cases, some of which doubtless would not have fared so well with a general anesthetic. For examples may be mentioned traumatic amputations and gunshot wounds of the abdomen, who came into the hospital shocked and apparently pulseless; also cases such as inoperable

gastric carcinoma, where a gastro-enterostomy was performed, and operable gastric carcinoma, where a partial gastrectomy and gastro-duodenostomy was done.

The accompanying table will give you an idea of some work done under this form of anesthesia.

Besides the cases named, numerous other operations upon patients of all ages and in worse conditions were performed.

Another good feature which may be attributed to the spinal anesthetic is the change it has brought about in the time required for the performance of our operations. The surgeon, the assistants and nurses must be on the alert in order to make quick time and finish before the effect of our anesthetic is lost. Dr. Roos was exceedingly elated at the finish of his service because of the rapidity with which he was forced to operate, as well as the excellent results he attained. He is still employing stovaine in all of his private cases wherever possible, and maintains that if spinal anesthesia can be recommended for operative cases with pulmonary tuberculosis, heart and kidney lesions, as well as such depressing conditions contraindicating general anesthesia, it certainly can be recommended for sound, healthy individuals. His future ideas are to employ the smallest efficient dose, injected into the lumbar portion of the spinal canal, at the same time observing proper technique and asepsis. In conclusion, I must say that our results during the past 10 months with this form of anesthesia has been gratifying.

Up to date, Dr. E. G. Roos at the State Hospital has operated upon 221 cases under spinal anesthesia.

Name.	Age.	Operation.	Stovaine.	Time.
Mrs. E. H.	90 yrs.	Nailing a fractured femur.....	.6 cgm.	1½ hours.
Mrs. H. S.	50 "	Amputating leg above ankle. Setting fracture femur of other leg .....	.7 "	1 hour.
Mrs. M. C.	36 "	Resection head of femur.....	.6 "	2 hours 5 min.
Mrs. S. M.	78 "	Plaster cast to fractured femur.....	.5½ "	1 hour.
J. F.	20 "	Plaiting fractured femur.....	.4 "	1½ hrs. + chlor. ½ oz.
Mrs. E. McD.	60 "	Partial gastrectomy and gastro-duodenostomy.....	.5 "	2¼ hrs. + chlor. ¼ oz.
M. A.	3 "	Prolapse rectum.....	.2 "	for ¾ hrs.
F. W.	17 "	Bilateral salpingectomy and appendectomy.....	.5 "	¾ hr. + ½ oz. chlor. for ½ hr.
W. M.	65 "	Prostatectomy, suprapubic.....	.6 "	1 hour 10 min.
Mr. W. P.	27 "	Section for ruptured ectopic and dil. and curett., Babcock repair and amput. cervix.....	.6 "	1 hour.
Mr. B. D.	23 "	Dil. and curett. and section for bilateral salpingectomy, hysteropexy, bilateral oophorectomy.....	.5 "	1 hr. 25 min. + 1 oz. chlor. = ½ hr.
G. S.	14 mos.	Herniotomy and appendectomy.....	1½ "	1 hr. 10 min. + 1 oz. chlor. for ½ hr. and ½ oz. chlor. = to 30 min.
C. M.	13 yrs.	Gunshot wound, abdomen.....	.4 "	35 min.
J. E.	13 "	Curett. necrosed tibia.....	.4 "	10 min.

## HISTORY OF THE ANATOMISTS OF THE UNIVERSITY OF MARYLAND.\*

By ERNEST S. BULLUCK, M.D.,  
*Wilmington, N. C.*

After the close of the Revolutionary War the colonists turned their attention to affairs at home with such success that our country grew in trade and population for the first 20 years with surprising rapidity. At the close of this period one finds the people of Baltimore calling for increased efficiency of its physicians and a separation of the worthy from the unworthy practitioner.

Heading this movement we find Dr. Wiesen-  
 thal, who advocated the formation of a medical  
 society. It was after his death that the proposed  
 organization was completed by his son Andrew,  
 and beginning as the "Medical Society of Balti-  
 more," it later evolved into the present Medico-  
 Chirurgical Faculty of Maryland.

Under the auspices of this society in the year  
 1789 dissection was attempted. The body of a  
 criminal was procured, but the populace inter-  
 fered, took possession of the body and put an end  
 to the project. Despite this discouragement, Dr.  
 Andrew Wiesen-  
 thal lectured throughout the year  
 to a class of 15 students with such success that  
 the formation of a medical school was proposed  
 for the following session. The proposed school,  
 however, was never inaugurated, so the doctor  
 continued his private course.

About this time Dr. John Beale Davidge moved  
 to Baltimore. He was an Annapolis boy who,  
 having graduated from St. John's College, had  
 spent several years studying anatomy at the Uni-  
 versity of Edinburgh and later graduated at Glas-  
 gow University.

He came to the city when a youth with train-  
 ing and ambition, and after six years of practice  
 started a private course of lectures on anatomy.  
 For five years he continued this course of instruc-  
 tion. In 1807, having drawn about him Drs.  
 James Cocke and John Shaw, he founded the  
 "College of Medicine of Maryland," which was  
 later to become the Medical Department of the  
 University of Maryland. Dr. Davidge, to aug-  
 ment the teaching facilities in this department of  
 the new school, built at his own expense a small

anatomical theater and procured a subject for  
 dissection, but the fact became known; a crowd  
 gathered, which grew into a mob, who proceeded  
 to demolish the building and destroy its contents.

It was now deemed best to procure land on the  
 outskirts of the city, and to obtain legal protec-  
 tion they applied to the Legislature for a charter  
 for a medical college. The petition was favored  
 and the charter granted on December 18, 1807,  
 there being only four other medical schools in  
 this country at that time.

Under the new charter the teaching of anatomy  
 was divided between Davidge and Cocke. Lec-  
 tures began at once, delivered at the homes of the  
 teachers. During this year the class numbered  
 seven only, and there were no dissections. The  
 following year the lectures were delivered in a  
 dilapidated old schoolhouse on the southwest cor-  
 ner of Fayette street and McClellan's alley,  
 which was for four years the home of the Med-  
 ical Department of the University of Maryland.  
 Professor Cocke was an able anatomist, having  
 had the advantage of instruction under Sir Ashley  
 Cooper. He was also a good lecturer, and in 1812  
 was given full charge of the department of  
 anatomy.

At this time, the money having been previously  
 raised by lottery, the present medical building,  
 corner Greene and Lombard streets, was begun,  
 to be completed the coming session.

The session of 1813 found the school in the  
 new building, and Dr. Cocke was to have deliv-  
 ered the first lecture, but he fell ill and died at the  
 hour appointed for the lecture. He was the  
 school's first secretary, and the building, in which  
 he never lectured, owed much for its existence  
 to his keen business intuition. Dr. Davidge  
 taught obstetrics for a while, but he again as-  
 sumed the duties of anatomist.

At this time practical anatomy did not consti-  
 tute a prominent part of the course, and dissec-  
 tion was not compulsory. The present office of  
 the dean was given over to the work, as the second  
 floor of the building was not completed. There  
 being no demonstrator at this time, the room  
 usually fell in charge of the most zealous student.  
 Such a student was Godman of Annapolis, and  
 when, in 1817, Dr. Davidge was confined with a  
 broken thigh, Godman, conscious of his ability,  
 rose to the occasion and delivered the lectures  
 with such enthusiasm, mastery of words, gifts of  
 speech and power of imparting knowledge that he

\*Throughout this sketch I am constantly indebted to the  
 historical researches of Eugene F. Cordell, Professor of His-  
 tory of Medicine in the University of Maryland.

lent new interest to the subject and completely won the admiration of his fellow-students.

At the end of his course he wanted to stay with the school, but she offered him no inducement. He then made his home in the country. After a few years he founded a school of anatomy in Philadelphia. He later held many professorships and wrote extensively on anatomical and other subjects, and although his final attainment was great, it was without connection with the University, who lost in him the greatest anatomist of his time.

Some years later, owing to the resignation of Dr. Gibson, Dr. Davidge delivered the surgical lectures, and Dr. William Howard, an able assistant, was appointed to help in the anatomical work. The work was thus divided until 1829, when Dr. Davidge was found to have cancer of the antrum of Highmore. The course of the disease was very painful and rapid, and he was soon confined to his home.

For the remainder of the year his lectures were delivered by Nathan R. Smith, a promising young surgeon, who had previously taught anatomy in Jefferson Medical College. For the coming session Dr. John D. Wells was elected. He taught for one year, then returned to his home, where he later died of tuberculosis.

At the suggestion of Dr. Wells the lectureship was awarded to Dr. Benjamin Lincoln of Burlington, Vt., whose lectures were so satisfactory that at the end of the year the full professorship was tendered him, but he firmly refused, and returned to the enjoyment of his home, which he valued more highly than professional honors.

In 1831 the chair was filled by Dr. Thomas H. Wright of Baltimore, a prominent and able physician, but not particularly interested in the study of anatomy. He proposed that a Dr. Turnbull be appointed to assist him. Finding that the faculty had not acted upon his suggestion, he immediately resigned. During the same year the learned Eli Geddings was unanimously elected to that chair, which he held for five years, reflecting great honor upon the school. His resignation was due to the unsettled conditions in regard to the State control of the institution.

After leaving the University he returned to his native State and became professor of surgery in the medical College of South Carolina, from which school he had obtained his degree at the close of its first session.

In 1837, following Professor Geddings, the anatomical department again fell into the capable hands of Dr. Nathan R. Smith. After teaching for a year he resigned and left the University, but the duration of his absence was not long, and after a few years we again find him at the head of the department.

Previous to this time Dr. William Nelson Baker, whose father was a prominent member of the school's faculty, was conducting a private course in anatomy in the building in Cider alley, just behind the University. His class had been large and his ability recognized, so he was elected to the position vacated by Dr. Smith. He conducted the department with vigor and great success until 1841, when he died, having just attained the age of 30. He is represented as having been a man of great personal beauty and attractions, talented and with every promise of a brilliant future as a lecturer, anatomist and surgeon.

The chair of anatomy was again unoccupied, and Dr. Miltenberger, "the venerable old uncle" of the present professor of obstetrics, was sent North to hear the lectures of Dr. Joseph Roby of Boston. So favorable was the report of Dr. Miltenberger that Dr. Roby was immediately elected to the vacancy. After the assumption of his duties Dr. Roby's electors were more than satisfied. He worked from 9 to 3 o'clock daily, and was very particular about his dissections, censuring the smallest nick of the knife and insisting that the linen should be perfectly clean and white. During his administration dissection became compulsory (1848), there at this time being no American school that demanded dissection of its students.

This marked a new era in the teaching of anatomy, and was the beginning of the method that is destined to supplant the lecture. Indeed, the practical value of dissection seemed to have been realized at an early date, for we find advertised in the catalogues "abundant dissecting material," which notice has been recopied even to the present day.

During this same year illuminating gas was introduced into the dissecting hall "at great expense," and offered the opportunity to work at night.

After 15 years of service, during which time anatomical study at the University reached such importance that it commanded honorable recognition from all the great medical schools of our country, Dr. Roby's health began to fail, and from

then until two years later, when he died of tuberculosis, his lectures were delivered by the ever-efficient Dr. Nathan R. Smith.

The year 1860 opens with Dr. William A. Hammond, U. S. A., as professor of anatomy. Through his efforts microscopes were placed in the museum and one of the largest collections of slides in the country was at the command of the students.

The University of Maryland prides itself upon being the first school in America to teach microscopical anatomy, so another onward stride was made to a more perfect comprehension of this great subject.

Hammond withdrew from the University at the beginning of his second year and the lectureship again fell to the "ever present help in time of need," Nathan R. Smith, who completed the term and turned the department, in 1862, over to Christopher Johnson. This new teacher was an ardent student of histology and a skillful microscopist, and his work did much to promote the growth of this new phase of anatomy.

Previous to 1866 the professors of anatomy had also taught physiology, but now the anatomist was relieved of this branch; physiology being grouped under one lectureship with hygiene and general pathology.

In 1869, after the retirement of our so many times professor of anatomy, Nathan R. Smith, Christopher Johnson was elected professor of surgery. The vacancy was now awarded to Francis T. Miles, a South Carolinian, who had spent about 20 years at various other schools in anatomical work.

A few years later the course of instruction was extended from four to five months. Miles was an eloquent and attractive lecturer and continued in the department until eleven years later, when he was transferred to the department of physiology, where he served with great distinction.

Dr. J. Edwin Michael, having spent six years as demonstrator of anatomy, was awarded the professorship in 1880. During the following year the course was again extended, this time to five and one-half months. Again in 1890 the addition of one month was made to the course. At the same time, April, 1890, Michael was transferred to the chair of obstetrics. His previous position was then awarded to Randolph Winslow of North Carolina, who had since his graduation, 16 years before, pursued the subject with such

fervent zeal and masterly understanding as to clearly demonstrate his fitness for the position.

During the same year the course which had previously been two years, was extended to three. The resignation of Louis McLane Tiffany was soon to follow and the school must have another professor of surgery. The material was reviewed and, as had ever been the case, the best surgeon was found in the dissecting hall. Another anatomist was transferred, Dr. J. Holmes Smith, then demonstrator of anatomy, was made its professor.

The course was now made to cover seven and one-half months and later extended to its present length. During the nine years that he has occupied the chair of anatomy he has greatly enlarged the scope of its practical work. As a lecturer, he is unassuming, clear, concise, separating the wheat from the chaff and deeply impressing all essentials, and it is hoped that his term of service may be as long as it has been successful. For the vacancy that must some day occur the university will not find herself unprepared, for she has in her present demonstrator, Dr. Holland, a man of rare ability as a dissector with God-given genius for teaching. With the few words that denote wisdom and the generous manliness that encourages the weary and inspires the vigorous, he rules by his presence and receives co-operation and admiration in return.

The anatomical department gives to the student the most useful knowledge that he gains. It teaches the fundamentals upon which all future medical training must be based, so what could be more fitting and proper than that it should have mothered our school from the beginning. The other departments have drained it of its good men as they arose.

The chair of surgery owes its nearly every occupant to the dissecting hall. The school of anatomy has ever been the backbone of the university, and who would not cherish the tender memory of our greatest department and those who made it?

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Dr. William L. Rodman, professor of surgery in the Medico-Chirurgical College of Philadelphia, lectured in the University on "Surgery of the Stomach and Breast" on Friday and Saturday, March 22 and 23. Dr. Rodman was the guest of Prof. Randolph Winslow during his stay in this city.



# REPORT OF A CASE OF ABIOTROPHIC CORTICAL DEGENERATION WITH SECTION OF POSTERIOR SPINAL ROOTS FOR RELIEF OF SYMPTOMS.

By C. W. RAUSENBACH and W. M. SCOTT,  
*Class of 1912.*

*Name*—O. L.

*Address*—Baltimore.

*Age*—Seventeen years.

*Sex*—Male.

*Occupation*—None.

*Social Condition*—Single.

*Complaint*—"Spasms of arms and legs."

*Family History*—Father living and well. Mother living but in the Springfield Hospital because of insanity. Two brothers and two sisters living and well; no nervous trouble. One sister died at the age of seven; cause, membranous croup. Mother's form of nervous trouble "was sent to the above-mentioned hospital because of spells of nervousness coming on several times during the day and night, evidenced by sudden outbreaks of temper, with crying for about half an hour, and then hysterical laughter for about the same period of time. Occasionally she would run about the house, but never injured herself, nor was she ever absolutely unconscious. These fits would usually begin after some minor favor was asked of her or whenever she became excited." Family history is negative to malignancy, tuberculosis and kidney diseases.

*Past History*—At the age of ten had measles; no complications. Negative to diphtheria, scarlet fever, pertussis, chorea, sore throat, rheumatism, typhoid, malaria, influenza, pneumonia and pleurisy. Has always been healthy, but was delivered by instruments.

*Habits*—Smokes no cigarettes, cigars or pipe. Drinks no alcoholics (father is a wine drinker, but never becomes intoxicated). Denies ever having masturbated. Drinks coffee in moderation. Has regular habits as to sleep and meals, but always has been excitable.

*Present Illness*—Began about nine years ago, four months after being hit in left eye with a baseball. Began soon after being severely punished by father, who first noticed a twitching and contraction of the left wrist when in a semi-flexed position. This soon involved the entire arm and had spastic contractions which could not be controlled. In a short time the right leg became in-

involved and several other groups of muscles. The contractions occurred mostly in the flexors and could not be controlled, and they became worse, so that they would remain flexed for a short time. Then in two years the left arm became involved and in another year the left leg, but the involvement of this side has never been so severe. After a time the erector muscles became involved with these contractions. These contractions are not marked at night when asleep, but may be increased when awake by excitement or other causes.

*Gastro-intestinal Tract*—Some indigestion after meals with eructations of gas. Somewhat constipated.

*Pulmonary and other tracts* are negative.

## LABORATORY FINDINGS.

*Urine*—Albumin and sugar are absent, reaction acid, specific gravity 1032, straw color, aromatic odor, some sediment, few epithelial cells and hyaline casts, little mucus and granular debris.

*Blood*—Leucocyte count, 7200.

Haemoglobin, 87 per cent.

Blood pressure, 110.

Three Wassermans made and all proved negative.

*Physical Examination*—At the time of examination patient, a white boy, 17 years old, sitting in a semi-recumbent position, showing no evidence of acute pain, but having numerous violent involuntary contractions of his extremities and more marked on his right side and suffering from dyspnoea. His mentality is exceptionally good and his intellectual faculties are well developed.

Head of medium size, covered with a thick crop of black hair, no areas of alopecia, no scars noted, occipital protuberance prominent. Eyes: The right eye is smaller than the left, pupils are equal and somewhat dilated, react normally to light and accommodation, field of vision normal, ocular motion good, sclera of a pearly hue, conjunctiva somewhat anaemic with tortuous vessels, ocular tension normal. Ears are large, low set, no topi, nor mastoid or accessory sinus tenderness, no discharge, hearing on the right side is obtunded. Nose is prominent and large, cartilaginous portion is slightly displaced to the right and the left nostril larger than the right.

Mouth—Palate is broad and slightly dome-



shaped, mucous membrane is anaemic, tonsils are slightly enlarged, peritonsillar ring is injected, pharynx is bathed with a serous secretion from the posterior nares, teeth are in a good state of preservation, gums firmly adherent, no pyorrhoea. Tongue protrudes slightly to the right and has a fibrillary tremor, dorsum is of a good color and is not coated.

Neck is short, well rounded and developed. There is a spasticity of sterno-cleido-mastoids and especially of the right; no tracheal tug, no abnormal pulsations, submaxillary glands are palpable but not markedly enlarged.

Chest is markedly distorted, covered with heavy and well-developed muscles, which are in a state of constant contraction, there is a marked flaring outward of the entire costal margin on both sides, causing the lower opening of the thorax to be expanded and greatly resembling a much-exaggerated Harrison sulcus. Costo-xiphoid angle is about 85 degrees, no scars noted, expansion equal on both sides, but respirations entirely of a thoracic type, which is greatly impaired by the tonic contractions of these muscles, frequently causing dyspnoea. After deepest inspiration the chest measures 71 cm. and after the fullest expiration chest measures 67 cm. Palpation of the chest no friction fremitus, no abnormal pulsations felt, tactile fremitus is normal. Percussion of the chest normal except at the right apex where percussion note is flattened. Auscultation of the chest: Breath sounds very hard to ascertain because of the numerous contractions of the muscles, but his respiration is harsh, somewhat puerile in character, short and jerky.

Spine—No spinal tenderness, no kyphosis or other abnormalities, has a linear scar 30 cm. in length and beginning at the fifth dorsal vertebrae and extending downward. This scar is due to a laminectomy. All the muscles of the back are in a state of clonic contractions.

Heart—It is impossible to ascertain the exact condition because of his constant involuntary movements. The heart sounds are, however, very rapid and distant—no murmurs made out.

P. M. I. is neither visible nor palpable. Palpation over the precordium showed no distinct shock nor thrill.

Liver—It is impossible to palpate it because of rigidity of the muscles of the abdomen, but there are no areas of tenderness over it.

Abdomen—Has a very flat abdomen, muscles

are very well nourished and hard as a board from their tonic contraction and especially marked on the right side. There are no areas of tenderness. There is no distention of the abdomen nor meteorism. Because of abdominal rigidity it is impossible to palpate the spleen or kidneys.

Inguinal glands are palpable on both sides, but not markedly enlarged, there is no phimosis, paraphimosis, no scars and genitalia are apparently normal.

Lower Extremities—Muscles of the right side are somewhat atrophied and in a state of tonic contraction with intermittent clonic contractions causing involuntary and inco-ordinate movements of the leg. The tonic contractions of the muscles of the right leg produce an abduction of the foot which he cannot voluntarily overcome. No scars noted, joints are not swollen, inflamed nor tender, and there is no roughening of the tibia. Left leg: There is a marked atrophy of the muscles of the thigh and leg and they are not in a state of tonic contraction but are flaccid. There are no joint involvements, no scars, foot drop is present and the skin is loose and inelastic.

Upper Extremities—Well developed, muscles are in a state of clonic contraction causing a marked extension and separation of the fingers, which also have athetoid movements and especially of the right. No scars, glandular enlargements nor joint involvements. Pulse is of low tension, small volume, very rapid (150 per minute), and there is no marked fibrosis of the radial vessels.

*Neurological Examination.*—Patient's intelligence very well developed, talks intelligently on all topics of the day; speech, apparently no evidence of aphasia or of articular disturbances; recognizes all objects well, memory for remote and recent events is exceptionally good; at present has no use of left lower limb; no evidence of hemiplegia; all muscles except those of expression and mastication are in a spastic condition.

*Motor Examination.*—The muscles of the neck, shoulder and back are of good muscular power. The extensors of both arms and flexor group of left arm possess their normal muscular power, but the flexors of the right arm are somewhat weakened. Both the extensors and flexors of the right forearm are also weakened. The flexors of the left thigh are paralyzed, those of the right are weakened; and the extensors of the left thigh have also partially lost their normal muscular

power. The flexors of both legs and the extensor of left are markedly weakened. There is a weakening of the flexors of the right foot and the extensors of the left foot, and a paralysis of the flexors of the left foot producing a foot drop.

*Trophic Disturbances*—All the muscles are somewhat atrophied, there is a marked atrophy of those of the left limb. Over the right ischial tuberosity there is a small decubital ulceration about the size of a penny.

*Abnormal Movements*—There is a constant, irregular, uncontrollable, partly atheoid, partly choreiform contraction of the muscles of the entire body with the exception of those of mastication, expression and lower left extremity. These movements occur both during rest and activity. During sleep the inco-ordinate contractions cease and the muscles are somewhat relaxed. During excitement the contractions become most violent, causing profuse perspiration, tetanic contractions of respiratory spinal muscles, causing respectively dyspnoea and a semi-opisthotonic position. At times the arms may be violently affected with little or no involvement of the leg; and conversely the legs may be violently affected with little or no involvement of the arms.

*Co-ordination of Muscles*—He has absolutely no control over the affected muscles and attempts to perform actions requiring co-ordination of these muscles exaggerate the passive atheoid and choreiform contractions.

*Reflexes*—The abdominal, cremasteric, left plantar and left Babinski are absent; *i. e.*, they do not respond at all to stimuli. The left ankle clonus is suggestive and the right is positive. Right Babinski markedly positive. The triceps reflexes are exaggerated; the periosteo-radials, the right knee and tendo-achilles are not obtainable due to the tonic contractions of the muscles concerned in these reflexes; and the knee and tendo-achilles of left limb fail to react to stimuli. There is a presumptively positive left Kernig's sign, which, however, is in all probability due to an atrophic shortening of the posterior group of muscles of the thigh which are the flexors of the leg.

*Sensory Examination*—Muscular and pain senses are normal.

*Temperature Sense*—There is analgesia over inguinal, hypogastric, lower half of dorsal, lumbar and sacral regions and extending over the buttock. There is decreased perception of sensation

over right leg, left thigh, upper half of anterior surface of left leg. Over posterior and lower half of anterior surface of left leg there is a misinterpretation of temperature sense causing feelings of warmth when either heat or cold are applied. There is also complete analgesia of entire left foot.

*Tactile Sense*—There is complete anaesthesia over lower inguinal, and hypogastric regions, over back beginning at fifth dorsal vertebra, extending downward to buttock and outer and dorsal surface of left foot.

*Stereognostic Sense*—Apparently normal. There is a numbness, paleness and coldness of the entire left limb.

*Cranial Nerves*—The auditory nerve on left side is somewhat involved causing an obtunding of the sense of hearing in left ear. There is an involvement of both spinal accessory nerves, especially of the right, causing a tonic contraction of the trapezius and sterno-cleido-mastoid most marked in the latter muscle. Hypoglossal is involved, causing the tongue to protrude slightly to the right of median line. All the other cranial nerves are normal.

## ITALIAN SUPERSTITION IN REGARD TO PLACENTA.

By E. J. NAR HANSEN, M.D.,  
New York, N. Y.

Dr. J. Johnson of Copenhagen writes in *Ugeskrift for Læger* an amusing account of a disgusting superstition found among the lower classes in Italy.

In 1907 the water in the public well in Maggione became so bad that the mayor sent samples of it to Dr. Bellucci, professor in chemistry in Perugia, asking him to have them examined.

The examination showed that the water was contaminated by organic matter. Dr. Bellucci expressed the opinion that some dead animal was at the bottom of the well, and that it would be necessary to empty and thoroughly cleanse it. This was done. No animal was found, but the bottom was filled to a height of four to five feet with numerous clay bowls, carefully bound up, and each containing a decayed mass, which on closer examination proved to be *human placentae*. These were so numerous that Bellucci found the space filled by them measured nearly two and a half cubic yards. By questioning a number of

the inhabitants he found that the throwing of the placenta into the well was an ancient custom, so strictly kept that it had been impossible to keep the well covered.

This discovery started Dr. Bellucci on the trail concerning the Italian superstition in regard to placenta (*vide Archivio per l'antropologia e la Etnologia*, Vol. XI), and he found that in the popular superstition placenta was always connected with either involution of uterus or lactation, or both. If placenta is not promptly expelled, the magical art is resorted to.

In many places the husband's hat is placed on the patient's head or his trousers are placed on her abdomen. Still better, horseshoes are sometimes used, part of the shoe being introduced into the vagina. In other parts the woman must blow into a bottle, and at the same time all windows and doors must be kept open, otherwise the uterus will not retract.

When at last the placenta is expelled, it must be placed in a bowl underneath the bed exactly below the shoulders of the patient. There it remains for three days until the flow of milk has started. As soon as that has taken place the placenta is buried, sometimes with salt, symbolic of sagacity, or with grain, symbolic of richness.

The placenta must be buried in a moist place, beneath the outlet from the roof, in a dunghill or in a cemetery. It is best to throw it into a spring or a well, as was done in Maggione, because the moisture of the burial place is very important to the lactation. If the placenta dries up, the milk will stop; but, on the other hand, the action of the placenta on the water makes it lactiferous.

Placenta is also used to hasten the involution of uterus, and is then placed on the abdomen of the patient. The afterpains are alleviated if the patient drinks a cup of soup made from the placenta, or if a few drops of blood are pressed and mixed with the yolk of an egg and given to the woman.

A very strange custom prevails in Sardinia. If a child is still-born, the navel cord is not cut, but the attendant awaits the expelling of the placenta. As soon as it arrives it is placed on a pan and fried, the child being kept close beside the pan. The hope of the parents and the attendants is that the heat will drive the baby's soul into the body through the uncut navel cord, and that the child may be brought to life.

New York, January, 1912.

## "PREVENTIVE MEDICINE AMONG OUR YOUTH."

By C. F. STROSNIDER, M.D.,

*District Director of Sanitation, North Carolina State Board of Health.*

The management of the child from infancy to the age of 16 years is the period of phenomenal development, and it is during this period that the foundations are laid of those factors which make most for success in after life—a well-developed body, sound health and a good digestion. In so far as these fall short of the normal, just so far does the individual miss his full effectiveness in the world's work.

The loss to the State of North Carolina in earning power from preventable diseases, such as tuberculosis, typhoid fever and hookworm, is enormous, even though we are already in possession of prophylactic measures of every-day medicine which, if conscientiously applied to each member of the community, would produce incalculable results.

Few will deny that the recent victory of Japan over Russia, which was up to this time thought to be the peer of any nation as regards army efficiency, was due to Japan's sanitation. Russia lacked that fundamental which so many sections of our State are deficient in today, and that is the application of the principles of sanitation. Japan taught the world the most practical and demonstrative lesson ever enunciated in sanitation. War records previous to the Russo-Japanese War showed that equally as many, and oftentimes more, men succumbed to disease as to bullets.

So long as it is considered good business policy to study and apply devices which make labor more effective, there is nothing vague or visionary in applying to the future laborer health-saving devices which will make him physically and mentally fitter for his work.

Since the foundations of a sound physique are laid in infancy and childhood, and if neglected cannot be rebuilt, we have a problem worthy of our most earnest consideration. When we consider the cost of living out of proportion to the increase in wage we have a condition which enhances rather than lessens these hereditary and congenital weaknesses which cause many deaths in early infancy.

The question of hygiene and sanitation is an educational one which will take much time to get firmly fixed in the minds of our good people.

We must make it plain to our people that no man has a right so to keep his house or so to live his life in a civilized community as to jeopardize his neighbor's health or happiness. Again, the duty of keeping clean in a physical sense is as high as that of moral cleanliness.

Is it not infinitely wiser to prevent the pollution of our drinking water or food than to fight the result of that pollution, as is the case with typhoid fever gotten by drinking dirty surface water or eating food polluted by flies which have come in contact with a typhoid fever case?

Again, is it not wiser to prevent soil pollution by using sanitary privies and thereby eradicate hookworm disease, which at present exists in the Central and Eastern part of our State to the extent of from 36 to 58 per cent., than to allow this easily-preventable disease to go on sapping the life-blood out of our beloved children, dwarfing them mentally and physically for life, and in numerous cases, directly and indirectly, by other diseases, causing death?

Shall we not vaccinate all our people at a cost of 25 cents each, rather than leave some hundreds to die annually and other thousands to be branded with scars, a living shame to the community?

Would it not be wise to prevent stagnant water around our homes and thus not have a mosquito hatching place and screen our home at a small cost against the mosquito, which causes malaria or bilious fever, than to allow this pest to enter our homes and cause long illness and oftentimes death?

Then we must start with the little ones, and after seeing that their mothers are instructed in the hygiene and clothing, remove the notion that the children must of necessity have measles, whooping-cough and hookworm disease by showing them that these diseases are ideal foundations on which to build future woe in the shape of consumption.

The best way to fight consumption or any other disease is with a sound body; the boy who would grow up to be a man of affairs must have sound lungs, stomach, eyes, ears, teeth and good muscular development.

Every school in the State should have a medical supervisor or inspector to inspect the eyes, mouth, ears and general condition of all children

in attendance, in order that disorders may be detected at a time when they could be cured. As an example, cross-eyes, detected early, can be cured; ear trouble, detected early, can be cured; diseased tonsils, removed early prevent rheumatism and poor health. Hundreds of our friends are today going through life cross-eyed, or blind, near or far sighted, or deaf, or dwarfed mentally or physically from hookworm disease, as a result of not receiving attention at the proper time.

For the advancement of so important an issue, let us place the far-reaching and lasting good of this work before our lawmakers and insist that they at least appropriate as much for the protection of their wives and little ones as for that of their swine, cattle and poultry.

Shall we make preventive medicine a very real power in our State? Or shall we be content to consider it a side issue?

Goldsboro, N. C.

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Prof. Randolph Winslow has received the following note in reference to his recent series of articles upon his trip to the Pacific Coast:

"Tis wonderful why one, when writing about fish, can't maintain the same conservative, moderate statements they do when expressing themselves about mountains, canyons, geysers, rivers, lakes and other marvelous footprints of the Creator. Who the devil ever heard of a fish being caught and cooked under such circumstances? In spite of the fish yarn, you have written us a series of most interesting and instructive papers. When your surgical day is passed, you can turn your attention to travel and recording what you see.

"Yours truly,

"D. W. BULLUCK (class of 1873),

"Wilmington, N. C."

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For the fish story see January BULLETIN, page 203, illustration on page 204.

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Dr. William Clinton Marett, class of 1911, has resigned as a member of the medical staff of the tuberculosis hospital at Bayview, and has accepted a position as assistant resident physician at Whitehaven Sanatorium, Pa. He will enter upon his new duties June 1.

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Dr. Harry Benjamin Messmore, class of 1910, is located in Brownsville, Pa.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, APRIL 15, 1912.

## AN EXPLANATION AND AN APPEAL.

For a year we have been publishing the names of those who have subscribed to the Pathological Endowment Fund, until the number has grown so large that it is inconvenient to publish the list in full. We shall, therefore, cease to present the names of each individual in each issue of THE BULLETIN, and shall only mention the names of new subscribers month by month. We shall, however, publish the amount subscribed by the individual classes of the medical alumni in each issue, as well as the total amount pledged, up to the first of each month.

As will be observed, almost every class that has left the portals of the Medical School in the past 40 years has thought enough of its Alma Mater to make some contribution to this fund. A few classes have not responded as yet to our appeal; in some instances, doubtless because they have not been solicited to do so. If any member of these classes should notice that his class is not represented in this list, we hope he will hasten to send us a contribution, in order that his class may have some part in this work. If anyone notices that his class has only a small sum credited to it, we hope he may add something to the class fund. If anyone thinks he can increase his contribution comfortably, his generosity will be greatly appreciated.

The past month has been rather barren of results. There has been so much to occupy our attention that not much effort has been bestowed on this enterprise. We hope, however, that the ad-

vent of spring will lighten our labors, and that coin, to say nothing of green and yellow-backed bills, may flow so abundantly into the coffers of our friends that they will have enough to spare us some of the overflow.

*Friends, help us!*

### CONTRIBUTIONS BY CLASSES.

1848.....	\$50 00
1868.....	10 00
1871.....	35 00
1872.....	65 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	35 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	15 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	70 00
1898.....	80 00
1900.....	215 00
1901.....	175 00
1902.....	305 00
1903.....	300 00
1904.....	145 00
1905.....	200 00
1906.....	130 00
1907.....	110 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Latin-American Club.....	25 00

Total subscriptions to April 1, 1912. \$9805 50

Subscriptions in March:

Dr. Nathan Winslow, 1901 (second contribution).....	\$50 00
Dr. Randolph Winslow, 1873 (second contribution).....	100 00

Dr. Erasmus H. Kloman, 1910 (second contribution).....	25 00
Additions for the month.....	\$175 00

### ITEMS

By request, we publish the following list of the class of 1905, with their present locations, so far as we are able to ascertain:

Elmer Hall Adkins.  
 Julian Warrington Ashby, Hugheston, W. Va.  
 Samuel Luther Bare, Westminster, Md.  
 Robert Parke Bay, 1701 Guilford avenue, Baltimore, Md.  
 Chandos M. Benner, Taneytown, Md.  
 James Snow Billingslea, Armiger, Md.  
 Alvah Parrish Bohannon; can't locate: in the State of Virginia; not in practice.  
 Vance W. Grabham, Bamberg, S. C.  
 Baird U. Brooks, West Durham, N. C.  
 Frank Burden, Paw Paw, W. Va.  
 Ira Burns, Relief Department, Pennsylvania Railroad Co., Wilmington, Del.  
 Roscoe C. Carnall, Waverly Mills, S. C.  
 John Joseph Carroll, 120 Chestnut street, Holyoke, Mass.  
 Edward Lawrence Casey, Woodstock, N. H.  
 Sydenham Rush Clarke, 423 Hawthorne road, Roland Park, Md.  
 Edward V. Copeland, Round Hill, Va.  
 Arthur Bascom Croom, Maxton, N. C.  
 Charles Callery Croushore, 108 West 2d street, Greensburg, Pa.  
 Frederick De Sales Chappelier, Lewes, Del.  
 Seth De Blois, Newport, R. I.  
 David Alphonse De Vanny, 132 East 61st street, New York, N. Y.  
 Alpheus Wood Disosway, Plymouth, N. H.  
 Manuel Dueno, Anasco, Mayaguez, Porto Rico.  
 James Eugene Dwyer.  
 John Martin Elderdice, Mardela Springs, Md.  
 Oliver Justin Ellis, South Royalton, Vt.  
 Harry Moore Felton, 109 Climax street, Pittsburgh, Pa.  
 Edwin Ferebee Fenner, Henderson, W. Va.  
 William Henry Fisher, Centreville, Md.  
 John Shaw Gibson, Gibson, N. C.  
 Milton R. Gibson, Maxton, N. C.  
 Leo J. Goldbach, 2217 East Pratt street, Baltimore, Md.  
 Archibald Wright Graham.

William W. Hala, New York, N. Y.  
 Samuel William Hammond, Lambert's Point, Norfolk, Va.  
 George Blight Harrison.  
 Henry Hiram Hodgin, Red Springs, N. C.  
 Henry C. Houck, 1914 Pennsylvania avenue, Baltimore, Md.  
 Hamner Carson Irvin, Jr., Roanoke Rapids, N. C.  
 Brooke I. Jamison, Jr., Emmitsburg, Md.  
 Francis White Janney, The Walbert, Baltimore, Md.  
 Harry Aquilla Jenkins, Assistant Surgeon, U. S. N., now on board U. S. S. Montana.  
 Oswald Ottmar Kafer, Newbern, N. C.  
 Nagib Kenawy, 11 Boulevard de Ramleh, Alexandria, Egypt.  
 Eugene Kerr, Monkton, Md.  
 Herbert L. Kneisley, Hagerstown, Md.  
 William A. Knell, Augusta avenue and Frederick road, Irvington.  
 Kalil Magib Koury.  
 Edgar Brown Le Fevre, Inwood, W. Va.  
 Julius Levin; died in Johnstown, Pa., February 12, 1912.  
 George William Mahle; died in Baltimore, Md., February 20, 1911.  
 James P. Matheson, Charlotte, N. C.  
 James G. Matthews, Paulsen Building, Spokane, Wash.  
 George Skinner McCarty.  
 Harry Downman McCarty, 613 Park avenue.  
 John P. McGuire, Clarksburg, W. Va.  
 William Cuthbert McGuire, Huntington, W. Va.  
 Roscoe Conkling Metzel, 1824 West North avenue, Baltimore, Md.  
 Harold Edson Miner, 51 Maple street, Holyoke, Mass.  
 Robert Levis Mitchell, 2112 Maryland avenue, Baltimore, Md.  
 William Morris Mitchell, 80 Kennedy street, Bradford, Pa.  
 John Albert Nice, Mt. Airy, Md.  
 Oscar S. Owens, Manchester, Va.  
 John W. Parker, Jr., Williamston, S. C.  
 W. Arlett Parvis, Acting Assistant Surgeon, U. S. A.; at present at Sorocco, N. M.  
 John William Pierson, 2806 East Baltimore street, Baltimore, Md.  
 Daniel E. Remsburg, Cresson, Pa.  
 Samuel T. R. Revell, Louisville, Ga.

William James Riddick, Assistant Surgeon, U. S. N.; at present at Naval Station, Guantanamo, Cuba.

William Wordsworth Riha, Danvers Hospital for Insane, Danvers, Mass. (?)

John L. Riley, Pocomoke City, Md.

John Edgar Rooks.

Anton George Rytina, 2204 East Monument street, Baltimore, Md.

Edgar McQueen Salley, Saluda, N. C.

Albert Leigh Sanders, 1113 North Gilmore street, Baltimore, Md.

Sturat Baskin Sherard, Gaffney, S. C.

John Holmes Smith, Jr., 2205 St. Paul street, Baltimore, Md.

W. Henry Smithson, Jr., New Park, Pa.

James Albert Stone, Shallotte, N. C.

Benjamin Franklin Tefft, Jr., Anthony, R. I.

William E. Ellicott Tyson, 2609 East Jefferson street, Detroit, Mich.

Frederick J. Wass, 136 East Duvall street, Jacksonville, Fla.

William Benjamin Warthen, Davisboro, Ga.

We would be very glad if some of our readers can supply the missing addresses.

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Dr. James G. Matthews, class of 1905, of Spokane, Wash., was a recent visitor in Baltimore.

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Miss George Allen Hutton, class of 1911, University Hospital Training School for Nurses, is recovering from pneumonia at the University Hospital.

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Dr. Francis Miles Chisolm, class of 1889, has given up his offices in the Farragut, Washington, D. C., and will devote his entire time to his home office, 1632 Rhode Island avenue N. W., Washington.

---

Dr. George W. Dobbin, class of 1894, was operated on for appendicitis at the Mercy Hospital March 15, 1912. He is reported to be doing well.

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Dr. Bennett Bernard Browne, class of 1867, has been confined to his home, 510 Park avenue, Baltimore, with a slight attack of blood poisoning, caused by a slight abrasion of the skin, incurred while operating.

Dr. John C. Hemmeter, class of 1884, gave a lecture on the "Physiologic Foundations of Piano Technic" before the Florestan Club, 522 N. Charles street, Baltimore, on March 19, 1912.

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We would be very glad if any of our readers can give us the present address of Dr. Vernon Hastings McKnight, class of 1910.

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Dr. Robert Alexander Warren, class of 1907, is located at Midway Inn, Hot Springs, Va.

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The following charter has been granted the Alumni Athletic Association:

THIS IS TO CERTIFY that the subscribers—

Irving J. Spear, residing in Baltimore City;

Nathan Winslow, residing in Baltimore City;

Daniel Base, residing in Baltimore City;

Fred H. Vinup, residing in Baltimore City, and

James W. Bowers, residing in Baltimore City,

all of whom are citizens of the State of Maryland, all being of full legal age, do hereby certify that we do, under and by virtue of the General Law of this State authorizing the formation of corporations, associate ourselves with the purpose of forming a corporation.

1. The name of the association is the "Alumni Athletic Association of the University of Maryland, Incorporated."

2. *We do further certify*, That the purpose for which said corporation is formed and the business or objects to be carried on and promoted by it are the promotion and advancement of athletics at the University of Maryland, the creation and maintenance of high standards of sportsmanship among the students of the University of Maryland, and for social and literary purposes, and that the said corporation is formed upon the articles, conditions and provisions herein expressed, and subject in all particulars to the limitations relating to corporations which are contained in the General Laws of this State.

3. *We do further certify*, That the principal office of said corporation will be located in Baltimore City.

4. *We do further certify*, That the said corporation is to have no capital stock.

5. *We do further certify*, That the said corporation will be managed by eight Directors, and that Irving J. Spear, Nathan Winslow, James W. Bowers, John Henry Skeen, B. Merrill Hopkinson, Samuel W. Moore, Daniel Base and John B.

Thomas—all of whom are citizens of the State of Maryland and actually reside therein—are the names of those who shall act as Directors of the said corporation for the first year, or until their successors are duly chosen and qualified.

*In witness whereof*, We have hereunto set our hands this first day of December, in the year nineteen hundred and eleven.

*Witness:*

Ws. to all.

JOHN HENRY SKEEN. (Signed.)

IRVING J. SPEAR. [SEAL.]

NATHAN WINSLOW. [SEAL.]

JAMES W. BOWERS. [SEAL.]

FRED H. VINUP. [SEAL.]

DANIEL BASE. [SEAL.]

*State of Maryland, City of Baltimore, to wit.:*

Before the subscriber, a Notary Public of the State of Maryland, in and for the City of Baltimore, personally appeared on this first day of December, nineteen hundred and eleven, Irving J. Spear, Nathan Winslow, Daniel Base, Fred H. Vinup and James W. Bowers, and did severally acknowledge the foregoing certificate to be their act.

Witness my hand and notorial seal,

JOHN HENRY SKEEN,

*Notary Public.*

I, one of the Judges of the Supreme Bench of Baltimore City, do hereby certify that the foregoing certificate has been submitted to me for examination; and I do further certify that the said certificate is executed in conformity with the law.

CARROLL T. BOND.

The Pennsylvania Chapter of the General Alumni Association of the University of Maryland has elected the following officers for the coming year:

President, Dr. Lewis H. Adler, class of 1859, of Philadelphia; vice-president, Dr. J. Bruce McCreary, class of 1892, of Shippensburg; secretary, Dr. J. C. C. Beale of Philadelphia; executive committee, Drs. Frank H. Gaverik, class of 1888, and Harry C. Stover, both of Harrisburg; William J. Steward, class of 1904, and W. H. Lowell, both of Lancaster; James C. Clawson, class of 1855, and Robert C. White, both of Philadelphia; Edwards F. Winslow of Bryn Mawr; Z. C. Meyers, class of 1890, and R. S. Neiman, both of York, Pa.

## ATHLETICS.

The basketball season has closed with a creditable record of clean playing and good sportsmanship on the part of the University team.

The lacrosse team has cancelled the remaining games of its schedule because of lack of practice. The game played with the Navy team on March 28 resulted in an easy victory for the middies, and was the only game played by the University twelve during the season.

The baseball team is making a strong bid for the intercollegiate championship of the State. Five games have been played, of which number the University boys have won three. The team is putting its best play against the colleges, and has been handicapped by an accident to Woodland, who sprained his ankle at the Westminster game. The record of the games is as follows:

The initial game of the season was played March 20 against the Navy at Annapolis. A great deal of local interest centered in the game because of the fact that Harry Ruhl and Harry Butler, both former St. John's College boys, played on the University team. The score was 5 to 3, in favor of the Navy.

The Baltimoreans started the scoring in the opening session, when they chalked up a run on Sherrill's hit, a pass to Whitworth, followed by O'Neill's single. Navy went one better in the third, on a fielder's choice, and Vaiden's long drive to left, which was good for three sacks, but he stretched it into a homer on Beach's poor handling of the throw-in.

In the fourth the visitors added two more, and Navy evened things up with a tally in the same session. In the sixth the middies clinched the game, when they registered two more, on a base on balls, an error and wild pitch by Woodland.

Vinson, Navy's star twirler of last season, was on the mound for four innings. Seibert, a southpaw, who replaced him, was more effective.

NAVY.						MARYLAND.									
A.B.R. H. O. A. E.						A.B.R. H. O. A. E.									
Osborne, lf.	4	1	0	0	0	Butler, 3b.	5	1	1	0	0	1			
Vaiden, 3b.	4	1	2	0	0	Sherrill, c.	5	1	2	8	1	0			
Fisher, rf.	4	0	1	1	0	Whitworth, lf.	4	0	2	2	0	0			
Abbott, 2b.	4	0	0	0	2	O'Neill, ss.	4	0	2	3	2	0			
Hall, 1b.	4	0	2	13	0	Smith, 1b.	4	0	1	9	0	0			
Adams, ss.	4	1	1	0	3	Jenkins, rf.	4	0	0	0	0	0			
Byers, cf.	3	0	1	0	1	Ruhl, 2b.	4	0	0	1	5	2			
Hicks, c.	3	1	0	12	2	Beach, cf.	2	1	0	1	0	1			
Vinson, p.	1	0	0	1	0	Woodland, p.	3	0	0	0	4	0			
Seibert, p.	3	1	1	1	0	Woods, p.	1	0	0	0	1	0			
Totals.	34	5	8	27	12	2	Totals.	36	3	8	24	13	4		
Navy.							0	0	2	1	0	2	0	0	x=5
Maryland.							1	0	0	2	0	0	0	0	0=3
Two-base hit—Vaiden. Three-base hit—Vaiden. Left on bases—Navy, 7; Maryland, 8. First base on errors—Navy, 3; Maryland, 2. Innings pitched—By Vinson, 4; by Seibert, 5;															

Two-base hit—Vaiden. Three-base hit—Vaiden. Left on bases—Navy, 7; Maryland, 8. First base on errors—Navy, 3; Maryland, 2. Innings pitched—By Vinson, 4; by Seibert, 5;



by Woodland, 5½; by Woods, 3½. Struck out—By Vinson, 5; by Seibert, 7; by Woodland, 3; by Woods, 3. Bases on balls—Off Vinson, 2; off Seibert, 1; off Woodland, 3. Hits—Off Vinson, 5; off Seibert, 2; off Woodland, 7; off Woods, 1. Wild pitch—Woodland. Umpire—Mr. McAtee of Baltimore. Time—2.10.

The next game, played March 27 against Washington College at Chestertown, resulted in a victory for the Maryland boys—3 to 0.

The University team showed great improvement over the playing during the Navy game. Coach Willse having detected the errors made in the former game and put the knowledge to good use in the practice field.

The work of Woods for the Varsity was of a high order, as he allowed but three hits and walked one man. Biddle, for Washington College, was touched up for seven hits and gave several bases on balls.

The University started its scoring in the first inning.

Harry Ruhl played a star game for the University at the first base. This was Ruhl's first try-out in this position, and he made good.

WASHINGTON.						UNIVERSITY OF MD.							
ABR. H. O. A. E.						ABR. H. O. A. E.							
Meekins, 3b.....	4	0	0	0	4	1	Butler, 3b.....	3	0	2	0	0	0
Brown, 1f.....	4	0	2	2	0	0	Beach, cf.....	4	0	1	2	0	0
Kelly, 2b.....	4	0	0	3	2	0	Whitworth, c.....	4	1	1	1	2	0
Porter, 1b.....	4	0	0	12	0	0	Jenkins, 2b.....	4	0	0	1	3	0
Garrett, cf.....	3	0	0	2	0	0	O'Neill, ss.....	4	0	0	2	2	0
Lewis, ss.....	3	0	0	2	0	1	Smith, rf.....	4	1	1	0	0	0
Long, c.....	3	0	1	3	2	0	Ruhl, 1b.....	4	1	1	13	0	0
Wallace, rf.....	3	0	0	0	1	0	Blalock, lf.....	4	0	1	0	1	0
Biddle, p.....	3	0	0	1	5	6	Woods, p.....	4	0	0	0	5	0
Totals.....	31	0	3	25	14	2	Totals.....	35	3	7	21	13	0

Score by innings:  
University of Maryland..... 1 0 0 0 0 0 1 0 1-3  
Washington..... 0 0 0 0 0 0 0 0 0-0  
Two-base hits—Butler, Blalock, Brown. Three-base hits—Long, Smith. Sacrifice hits—Washington, 2; University of Maryland, 1. Stolen bases—University of Maryland, 2; Washington, 1. Double play—Biddle to Porter. Bases on balls—Off Biddle, 2; off Woods, 1. Batters hit—By Biddle, 3; by Woods, 1. Struck out—By Biddle, 3; by Woods, 5. Passed ball—by Woods to catcher. Left on bases—Washington, 4; University of Maryland, 7. Time of game—1.55. Umpire—Pensmith.

The third game was played against Western Maryland College March 30. Our boys won—8 to 4. Woodland did splendid work, but was hurt in the fifth inning and has been unable to play since. The score was:

UNIVERSITY OF MD.						WESTERN MARYLAND.							
A.B.R.H.O.A.E.						A.B.R.H.O.A.E.							
Butler, 3b.....	6	1	0	1	3	1	Jones, cf.....	4	1	0	2	0	0
Beech, 1f.....	4	2	2	2	0	0	Sprague, 1b.....	4	0	0	11	1	1
Whitworth, c.....	6	2	2	10	2	0	Beale, c.....	4	2	3	9	3	0
Smith, rf.....	3	0	0	1	0	0	Graefe, rf.....	3	0	0	1	0	0
Nitsche, rf.....	2	0	0	0	0	0	Myer, lf.....	2	1	1	1	0	0
Cooper, cf.....	2	2	1	1	0	0	Foltz, ss.....	3	0	0	0	3	1
Jenkins, 2b.....	5	1	2	2	2	1	Friesler, 3b.....	3	0	0	1	4	0
O'Neill, ss.....	4	0	0	0	2	1	Hill, 2b.....	3	0	0	2	0	1
Ruhl, 1b.....	4	0	0	10	1	0	Howard, p.....	3	0	1	0	0	0
Woodland, p.....	2	0	0	0	0	0							
Woods, p.....	2	0	1	0	1	0	Totals.....	29	4	5	27	11	3
Totals.....	40	8	8	27	11	3							

University of Maryland..... 0 0 1 0 3 0 1 1 2-8  
Western Maryland..... 2 0 0 0 1 0 0 0 1-4  
Two-base hits—Beale, Jenkins. Three-base hits—Beale (2). Stolen bases—Butler, Whitworth (2), Jenkins, Cooper (2). Balle. Bases on balls—Off Woods, 1; off Woodland, 3; off

Howard, 6. Batters hit—Beale (2). Struck out—By Woods, 2; by Howard, 5. Time—2.10. Umpire—Dooley, W. M. C.

The fourth game, slated against Mt. St. Mary's College April 2 at Emmitsburg, Md., was called off because of rain.

The fifth game was played against Dickinson College at Carlisle April 6, and gave the Maryland team a victory of 3 to 2. The weather was ideal and the game well attended. The Maryland boys showed their superiority over the Carlisle boys both in fielding and in batting. The score was as follows:

UNIV. OF MD.					DICKINSON.						
R. H. O. A. E.					R. H. O. A. E.						
Butler, ss.....	2	0	1	1	0	Stechel, ss.....	0	1	3	1	2
Jenkins, 2b.....	0	2	5	1	1	Goldstein, c.....	0	2	2	1	0
Whitworth, c.....	0	3	10	1	0	Hoch, cf.....	2	1	11	1	0
Smith, cf.....	0	3	0	0	1	Henderson, 1b.....	0	0	1	3	2
Nitsche, lf.....	1	2	0	0	0	Grimm, 2b.....	0	1	1	1	0
Ruhl, 1b.....	1	0	10	0	0	Rowley, rf.....	0	0	0	1	0
O'Neill, ss.....	1	2	0	4	0	Priece, 3b.....	0	1	4	0	0
Morton, rf.....	0	0	0	0	0	Patterson, lf.....	0	0	0	0	0
Wood, p.....	0	0	1	4	0	Shaffer, lf.....	0	0	3	0	0
	—	—	—	—	—	Brenneman, p.....	0	0	1	0	1
Totals .....	5	11	27	11	2	York, p.....	0	0	1	4	0
						Totals .....	2	6	27	12	5
University of Maryland.....	1	0	0	0	1	2	1	0	0	5	—
Dickinson .....	0	0	0	0	0	0	1	0	1	2	—
Two-base hit—Smith. Home run—Hoch. Bases on balls—Off York 1; off Wood 9. Struck out—By York, 3.											

The sixth game was played against the Baltimore (International League) team, and was won by the Orioles by a score of 16 to 6. The University team kept in reserve its best players for later college games and put its weakest team against the Orioles, trying out a new pitcher in one inning. Nine runs were scored in this one inning. Much interest was added to the game in the fact that Unglaub, a University of Maryland man in the days of Micky Whitehurst, was playing on the Oriole team, and made one run against the boys of his Alma Mater. After the fourth inning Manager Dunn of the Orioles changed his line-up, bringing in his reserves. The *Sun* writes: "In the field the losers played cleaner ball than the Orioles, but several errors of omission were costly." Several hundred students sat in the grandstand and cheered the University boys. The score was:

BALTIMORE.											
Player.	AB.	R.	H.	T.R.	SH.	SB.	SO.	BB.	P.	A.	E.
F. Maisel, ss.....	3	2	2	2	0	1	0	1	1	1	2
Twombly, ss.....	2	0	0	0	0	0	0	0	0	1	1
Corcoran, rf.....	4	2	4	6	0	0	0	0	0	0	0
Cooper, rf.....	2	0	0	0	0	0	1	0	0	0	0
Gutman, cf.....	2	3	1	2	0	1	0	2	0	0	0
Murray, cf.....	2	0	1	2	0	0	0	0	1	0	1
Schmidt, 1b.....	3	1	1	3	0	1	0	1	1	9	0
G. Maisel, 1b.....	2	0	0	0	0	0	0	0	5	0	0
Walsh, lf.....	6	1	2	5	0	2	0	0	0	0	0
Parent, 2b.....	1	2	1	2	0	1	0	2	0	2	1
Unglaub, 2b.....	3	1	1	1	0	0	0	0	0	2	1
Murphy, 3b.....	3	2	2	3	0	0	0	2	0	4	0
Payne, c.....	3	1	2	3	0	0	0	1	11	0	1
Russell, p.....	5	1	0	0	0	1	3	0	0	1	0
Totals	41	16	17	29	0	7	4	9	27	11	7

## UNIVERSITY OF MARYLAND.

Player.	AB.	R.	1B.	TB.	SL.	SR.	SO.	BB.	PO.	A.	E.
Butler, 3b.....	4	2	2	2	0	0	1	1	4	4	1
Ruhl, 1b.....	2	1	1	1	2	1	0	1	7	0	1
Whitworth, c.....	5	0	0	0	0	0	0	0	5	1	0
Smith, cf.....	5	2	2	5	0	1	1	0	0	0	0
Nitsche, lf.....	3	1	0	0	0	2	1	0	3	0	1
Jenkins, 2b.....	0	2	2	0	0	2	0	2	4	4	1
O'Neill, ss.....	4	0	1	1	0	0	2	0	0	0	0
Morton, ss.....	1	0	0	0	0	0	0	0	0	0	0
Cooper, rf, p.....	4	0	1	1	0	0	1	0	1	2	1
Woods, p.....	1	0	0	0	0	0	0	0	0	2	0
Metcalf, rf.....	2	0	0	0	0	0	2	1	0	0	0
Wannen, p.....	1	0	0	0	0	0	1	0	0	3	0
*Rowe.....	1	0	0	0	0	0	1	0	0	0	0
Totals .....	38	6	9	12	2	6	10	5	24	16	5

\*Batted for Cooper in the ninth.

Two-base hits—Parent (2), Corcoran (2), Gettman, Payne, Walsh, Murphy, Murray, Smith. Three-base hits—Schmidt, Walsh, Smith. First base on errors—Baltimore, 4; University of Maryland, 4. Left on bases—Baltimore, 11; University of Maryland, 12. Time—2.15. Empire—Mullaney.

To date the consensus of opinion of the sports news editors is that the Maryland team may well be proud of Butler, Ruhl and Woods.

## BIRTHS

March 9, 1912, Mary Eleanor Tucker, daughter of Dr. Henry McKee Tucker, class of 1899, and Mrs. Tucker, of Raleigh, N. C.

In February, Virginia Kathryn Messmore, daughter of Dr. John Lindsey Messmore, class of 1909, and Mrs. Messmore, of Masontown, Pa.

## DEATHS

Dr. John Evans Mackall, class of 1908, died at his home on Bright street, Elkton, Md., April 4, 1912, after a three weeks' illness of typhoid fever, aged 29 years. Dr. Mackall was the son of Mr. and Mrs. William H. Mackall of Elkton. He was educated in the public schools of Elkton and Delaware College. For two years after his graduation he was vice-principal of the Elkton High School, resigning to enter the University of Maryland, where he graduated in medicine in 1908. He then served for some time on the staff of physicians of the Atlantic Coast Line Hospital at Rocky Mount, N. C. He began practicing in Elkton about a year ago. Dr. Mackall was unmarried.

The funeral took place from his home on April 8, Rev. William Schouler of Trinity P. E. Church officiating. The Cecil County Medical Society met at the Union Hospital in Elkton and attended the funeral in a body. The pallbearers were William Pepper Constable of Baltimore, Ormond Chaytor of Wilmington, Del.; Stanley Evans of Elkton, and Drs. Robert L. Mitchell, class of 1905, of Baltimore; H. Arthur Mitchell and Howard Bratton, both of Elkton.

Dr. William T. Arnold, class of 1875, died at his home, 823½ W. Lombard street, Baltimore, March 3, 1912, after a lingering illness, aged 67 years.

Dr. Arnold was born in Baltimore, the oldest son of the late Francis and Sarah Mitchell Arnold. He was educated at the old Lester Academy of West Baltimore, and then entered the medical department of the University. After graduating there, he took a course at the Baltimore College of Dental Surgery.

Dr. Arnold never married. He gave up the practice of medicine because of ill-health about 20 years before his death. He is survived by three sisters and three brothers. Interment was in London Park Cemetery, Baltimore.

Dr. John Guy Hollyday, class of 1868, died at his office, 714 Frederick avenue, Baltimore, March 15, 1912, of pneumonia, in his 67th year.

Dr. Hollyday was born in Hagerstown, Md., May 10, 1845, the son of Richard T. and Susan (Ragan) Hollyday, and grandson of Colonel Ragan of Hagerstown, a hero of the War of 1812. Richard Tilghman Hollyday, Dr. Hollyday's father, was a farmer and slave-owner, and was born at the old Hollyday estate in Queen Anne's county, Readbourne, which only a few years since passed out of the hands of the Hollyday family.

Dr. Hollyday was educated in private schools and at Hagerstown Academy until he was 16 years of age, when the Civil War began. Dr. Hollyday and a companion started to join the Confederate Army, but after their intentions became known were forced to hide for several months in an attic in Dr. Hollyday's home, in order to escape capture by Union soldiers. They then joined the First Maryland Cavalry at Frederick, and served throughout the war. After it was over he came to Baltimore and studied medicine at the University, graduating in 1868, and being a house student during that year. For six months subsequently he served as a member of the medical staff of Bayview Hospital. He was for many years attending physician at St. Joseph's Monastery, St. Mary's Industrial School and Mount St. Joseph's College. Dr. Hollyday was a member of the Protestant Episcopal Church, but became a convert to the Catholic Church, and received the last sacrament at noon the day before

his death. He married in 1873 Miss Virginia Lamar, who survives him. Mrs. Hollyday was seriously ill at the time of her husband's death, and was at the home of her son-in-law, Capt. Samuel C. Cardwell, Fort Monroe. Dr. Hollyday had lived for many years at "Minnefield," on Edmondson avenue, extended. He was a member of the Masonic Order, and was connected with many of the most prominent families of the State. Besides his wife, he is survived by one son, Guy Tilghman Orme Hollyday; two daughters, Mrs. Virginia Ambler Cardwell and Miss Minnie Frances Hollyday, and a sister, Mrs. Thomas F. Billop. He was buried in London Park Cemetery.

## UNDERGRADUATE NOTES

*Under the Supervision of E. A. Looper.*

During the past month the Charles W. Mitchell Medical Society has been organized, composed of 40 University students, 25 seniors and 15 juniors, with honorary members from the faculty. The object of the society is to stimulate greater interest in the progress of medical science, and to bring the professors and students into closer relationship. Meetings are held each month, at which time certain students and honorary members are called upon to read and discuss papers of interest to the members of the society. At the organization the following officers were elected: Dr. Charles Mitchell, honorary president; G. C. Battle, president; W. M. Scott, vice-president; S. E. Buchanan, secretary; E. A. Looper, treasurer; B. J. McGoogan, historian; C. R. Edwards, corresponding secretary.

The names of the charter members are as follows:

Drs. Samuel Chew, Chas. Mitchell, Hiram Woods, John C. Hemmeter, E. F. Cordell, J. M. Craighill, Jos. E. Giehner, Gordon Wilson, Irving Spear, Chas. McElfresh, Jose Hirsh, Harry Adler, W. H. Smith, R. H. Johnston, H. D. McCarty, G. C. Lockard, W. Coleman, H. U. Todd; R. E. Abell, R. A. Allgood, G. C. Battle, H. A. Bishop, R. A. Bonner, S. E. Buchanan, J. D. Cochran, J. D. Darby, E. W. Frey, W. E. Gallion, D. O. George, J. E. Hair, M. Himmant, H. Irwin, E. S. Johnson, E. A. Looper, B. J. McGoogan, W.

Michael, W. M. Scott, J. D. Sharpe, E. A. Sherrill, T. F. Stevens, C. J. Stallworth, J. Terry, W. H. Yeager, J. M. Birch, R. B. Norment, V. E. Edwards, W. H. Toulson, W. O. Wrightson, H. J. Slucher, W. H. Scruggs, McDaniels, C. R. Edwards, E. G. Breeding, F. F. Callahan, C. A. Hayworth and F. D. Murphy.

\* \* \*

At the last meeting of the University of Maryland Medical Society a very instructive and entertaining lecture on The Eye, illustrated with stereopticon views, was delivered by Dr. Hiram Woods. Dr. R. Tunstall Taylor also read an interesting paper on the treatment of Anterior Poliomyelitis.

\* \* \*

Dr. C. B. Williams of Philippi, W. Va., is taking post-graduate work at the University Hospital.

\* \* \*

The editor of *Terra Mariæ* announces that the annual has gone to press, and will be ready for delivery May 1. Quite a number of the students have already engaged copies, and a large edition is being published.

\* \* \*

G. H. Lebet and H. R. Rich, senior students, have been sick in the University Hospital during the month, where they have undergone operations.

\* \* \*

The University baseball team opened up the season in Annapolis with a game against the Naval Academy, March 20. The score was 5 to 3 in favor of the Navy.

\* \* \*

Several of the senior students have already secured hospital appointments for the coming year. Mr. W. H. Yeager has been appointed superintendent of the Tuberculosis Hospital at Bayview, with Mr. G. C. Battle as assistant. Mr. E. A. Sherrill has secured an appointment in the surgical department at Bayview, and Mr. E. P. Kolb will be at the Robert Garrett Hospital for Children, while Mr. J. D. Darby has been appointed resident in the lying-in department of the University Hospital.

\* \* \*

On March 25 the first regular meeting of the Randolph Winslow Surgical Society was held,

at which time two interesting papers were read and discussed. The papers were "Some Facts Dealing with the Development of Aseptic Surgery," by R. A. Allgood, and "Surgical Aspects of Some Tumor Masses Found in the Neck," by Robt. E. Abell.

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### FRATERNITIES.

The Kappa Psi Fraternity entertained at its Chapter House, 1415 W. Fayette street, with a progressive card party on Washington's Birthday. Many of the old alumni and about 80 guests enjoyed the occasion.

\* \* \*

The Chi Zeta Chi annual fraternity dance was held at Lehmann's February 28. The dance was given by members of the Delta Chapter of the University, Rho Chapter of the College of Physicians and Zeta Chapter of the Baltimore Medical College. Mrs. Nathan Winslow and Mrs. H. U. Todd were sponsors from Delta Chapter.

\* \* \*

### IN HONOR OF DR. HIRAM WOODS.

The annual banquet of the Nu Sigma Nu Fraternity was held at the Hotel Belvedere March 15 in honor of Dr. Hiram Woods. Dr. John C. Hemmeter acted as toastmaster, and delivered a paper on "The Correlation of Medicine and Religion." This was followed by a series of talks relating to medicine in general and the fraternity. Among the other faculty members present were Drs. Hundley, Tarun, Hirsh, Adler, Taylor and Spruill. Those from the Hopkins Chapter were Drs. Barker, Welch, Finney and Cullen, and M. F. Dabney, A. W. Williams, F. Paschel and R. T. Dotson.

\* \* \*

The Baltimore Club of the Phi Sigma Kappa Fraternity gave its initial banquet at the Hotel Remmert Saturday night, March 2. The banquet was an extremely pleasant occasion, and was attended by nearly all of its alumni members. The toasts of the evening were principally relative to the Building Fund and the coming convention in Baltimore.

The speakers of the evening were Mr. G. H. Emory, "Law and Medicine"; Dr. Vernon B. Cecil, vice-president St. John's College, "St. John's"; Dr. H. A. Cotton, medical director New York State Hospital, "Older Days"; Dr. Arthur

M. Shipley, professor of pathological surgery and materia medica in University of Maryland, "Influence of Fraternities on Student Life"; Mr. Donald McLean, "The Council"; Dr. Frank S. Lynn, "The Coming Convention"; Dr. Nathan Winslow, "The Building Fund"; Mr. R. C. Williams of "Swarthmore," and Mr. W. H. Toulson, "Eta Chapter." Mr. Gilbert J. Morgan acted as toastmaster.

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### BOOK REVIEWS

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Vol. I, 22d series. 1912. Philadelphia and London: J. B. Lippincott Company. Cloth, \$2 net.

All of the articles in the present volume are above the normal in interest, but several stand out pre-eminently, namely, "Experimental Poliomyelitis," by Simon Flexner, M.D., of the Rockefeller Institute for Medical Research; "The Present Status of Our Knowledge Concerning the Etiology of Pellagra," by John Funcke, M.D.; "An Abstract Report of a Case of Transplantation of a Testicle," by Levi J. Hammond, M.D., and Howard A. Sutton, M.D., and "An Account of the College of Physicians of Philadelphia," by G. E. de Schweinitz, M.D.

As usual, there is a wide selection in the topics discussed, with a great wealth of information concerning the latest thought in the various specialties.

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### SOME ROUGH NOTES ON MODERN DIAGNOSTIC METHODS. New York: Fellows Company.

The above pamphlet contains in abbreviated form the essence of practical laboratory methods, such as the technic for the examination of blood, urine, sputum, the Wasserman reaction, serums, vaccines, etc. It is an extremely useful monograph, which the above-mentioned concern will gladly furnish upon request of physicians free of charge.

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No. 3

## A FRIENDLY CONTROVERSY BETWEEN TWO PHYSIOLOGISTS CONCERN- ING THE MECHANISM OF THE LESSER CIRCULATION (RETURN OF BLOOD FROM THE GILLS TO THE SINUS VENOSUS) IN ELASMO- BRANCH FISHES.

By JOHN C. HEMMEFER, M.D., Phil.D., LL.D.,  
*Professor of Physiology, University of  
Maryland, Baltimore, Md.*

In the *Zeitschrift für Biologische Technik und Methodik*, Bd. 2, p. 236, November, 1911, I published an explanation of the forces that bring the blood back from the gills to the sinus venosus in the heart of the *selachii*. This heart consists of sinus venosus, which is the first part of the heart located in the pericardium toward the caudal end; this empties into the single auricle, and this into the powerful ventricle. The ventricle sends its blood through the bulbus arteriosus and aorta to the gills.

Whilst the blood pressure in large specimens of dogfish, for instance, may be very considerable in the ventral aorta going to the gills, the vessels returning the blood from the gills show no positive pressure whatever, and we did not succeed in measuring whether there was any negative pressure with the instruments at our disposal at the Woods Hole laboratory during the summer of 1911. In three vigorous specimens of *mustelus canis* the pressure in the ventral aorta was 88, 92 and 96 mm. of mercury, respectively, but after the blood had been passed through the fine capillary network of the gills and re-collected again it shows no positive pressure whatever; but there is some slight evidence that the blood appears to be sucked caudad toward the sinus venosus. What causes this force to bring back the blood from the gills to the heart?

The influence of the respiratory motions of the

fish in favoring the return of blood to the sinus venosus has been described by me on page 238 of the above article.

But during a great many experiments I noticed that the pericardium was a very tough bag, and that it did not collapse to any noticeable degree when the ventricle contracted, but was about the same size during the systole and during the diastole of the ventricle. The ventricle is the strongest and most muscular part of the heart. When it contracts it becomes very much reduced in size, but as the pericardial sac does not become smaller during the ventricular systole, the thin-walled sinus venosus and auricle are sucked into the space vacated by the ventricle. In other words, there is a slight negative pressure created in the pericardium when the *auricle* and *ventricle* contract, and this is filled by the aspirating into this new space of the sinus venosus. This negative pressure is sufficient to fill the sinus venosus from the sinus of Cuvier. At times the respiratory muscles of the fish which draw the water into the mouth and out through the gill slits, contract simultaneously with the ventricle. Now, in some of these fishes the respiratory muscles (coraco branchial) exert a traction upon the pericardium, thus, as the ventricle gets smaller in size, creating a negative pressure in the pericardium, this sac, far from collapsing and following the ventricle, is pulled in the opposite direction by the outside traction of the respiratory muscles.

In the elasmobranch fishes there is an open canal which connects the pericardium with the peritoneum, known as the pleuro-peritoneal canal (pericardio-peritoneal canal would be a more correct designation), which drains the pericardium toward the peritoneum; owing to valves in this canal, however, no fluid can enter from the peritoneum into the pericardium. Therefore, a *negative pressure* is possible in the pericardium, but not a *positive pressure*, for if a positive pressure were ever created in any conceivable manner

it would be spent toward the peritoneum through this canal. Delicate water manometers tied into the abdominal side of this canal indicate always a slight negative pressure with each systole of the ventricle; never a positive pressure.

So the explanation I offered was that the return of blood toward the sinus venosus from the gills was due to a negative pressure in the pericardium caused in the manner described. When I explained this mechanism to my friend, Prof. G. H. Parker, who was working in the same laboratory (that of the United States Fish Commission at Woods Hole, Mass.), he informed me that this discovery had already been made by Léon Fredericq at Liège, and in the article written by me I credited Fredericq with having first explained the respiratory circulation in the fish and the return of blood to the heart in this manner. On the 8th of February, 1912, I received the following letter from Professor Fredericq:

"Most Honored Colleague—I have read in a very interesting article by you ('Methodik der Gleichzeitigen Registrierung des Atmungs- und Herzrhythmus beim Selachier') in the *Zeitschrift für Biologische Technik und Methodik*, November, 1911, p. 236, a description of a method concerning the return of blood from the gills to the sinus venosus in the fish which you credit to me. You will oblige me very much by indicating where you have found this method described, as I cannot recall having published anything concerning this subject. In expressing my thanks in advance, will you please accept the assurance of my most cordial sentiment?

"LÉON FREDERICQ.

"P. S.—You may reply in English or German, just as you prefer."

Thereupon I communicated again with Professor Parker, who sent me the following letter:

"Dear Dr. Hemmeter—The idea I had about the return of blood to the heart of a fish applied to those cases where, as in the skate, the walls of the pericardium are firm. My notion was that the contraction of the ventricle in a firm-walled chamber would of necessity cause the auricle to fill by sucking in blood from the venous sinus, etc. Such a condition would imply a negative pressure in the blood cavities immediately behind the heart. I remember talking this over with Dr. Willem at Naples, and he told me that this negative pressure had been demonstrated by Léon

Fredericq at Liège for certain fishes. This conversation was in 1893, and the whole affair is naturally somewhat hazy to me now, but I believe I never knew whether these observations of Fredericq's were published or not. I am sorry I can't send you more satisfactory information.

"Spaeth and I have just completed a hard half-year's work, and we are beginning to feel more ourselves again. With kind regards to Mrs. Hemmeter, I am,

"Very truly yours,

"G. H. PARKER.

"Zoological Laboratory, Harvard University,

"Cambridge, Mass., February 13, 1912."

On receipt of this letter from my friend, Dr. Parker, I sent the following communication to Professor Fredericq:

"Baltimore, February 15, 1912.

"M. le Professeur Léon Fredericq:

"My Dear Colleague and Honored Friend—From the error I have made in my article on 'Methodik der Gleichzeitig. Registrierung,' etc., in the *Zeitschr. f. Biologic. Technik*, Hft. 5, Bd. 2, November, 1911, p. 236, attributing to yourself a physiologic contribution which you say that you have never published, you will recognize one of the embarrassing accompaniments of your greatness, for discoveries are credited to you which you have never made.

"On the other hand, the error shows what undesirable complications we may be led into by overconfidence in our friends whom we know as great authorities. Inclosed I hand you a letter from my friend, Prof. G. H. Parker, professor of zoology at Harvard University, Cambridge, Mass.

"Parker worked in the Marine Biological Laboratory at Woods Hole, Mass., all of last summer, and I asked him about this very physiologic question concerning the return of blood from the gills to the heart in fishes, and he gave me to understand that you had done this work. Knowing Parker to be one of the greatest zoologists of our country and a very thorough and broadly-educated man, I did not doubt his statement, nor did I take the trouble to look up any reference on the subject.

"As I was teaching your contributions to respiration to my students every year, it seemed so natural and self-evident that you should also have made this discovery on fishes. If you desire

me to correct this error, I will send a letter to that effect to Prof. Martin Gildemeister, the editor of the above *Zeitschrift*.

"I may add that this mechanism of the negative pressure created in the pericardium of the elasmobranchs during the contraction of the auricle and ventricle was worked out by me at Woods Hole last summer, and I did not claim it as an original piece of work, because Parker stated that you had already made this discovery. As you now disclaim ever having done such work, it will be best for me to publish my experiments on this subject.

By invitation of Prof. H. J. Hamburger I hope to be in Groningen next fall to attend the meeting of the International Physiologic Society. Perhaps I will have the pleasure of seeing you and meeting you there.

"My new work, 'Manual of Physiology,' was published this week in Philadelphia. Can you tell me the exact date of the meeting of physiologists in Groningen?

"Hoping you are well, and with kindest regards, I am,

"Yours very sincerely,

"J. C. HEMMETER.

"739 University Parkway,

"Roland Park, Baltimore."

On March 10, 1912, I received the following reply from Professor Fredericq:

"Institute of Physiology, University of Liège,  
"February 29, 1912.

"My Dear Colleague Hemmeter—Thank you for your kind letter. Herewith I return Professor Parker's letter. I cannot imagine how Dr. Willem could have made the mistake of attributing to me merits which I do not possess. Indeed, I have never undertaken any work on the circulation of bony fish. With regard to other fish, I limited myself to the collection of blood, but never made any experiments in the circulatory mechanism.

"It does not seem worth while to trouble you with writing a correcting article. You will certainly have the opportunity of some day correcting this point, which is of no importance to me, in your future publications.

"I am glad of the opportunity which brought us in contact with each other, and hope to have the pleasure of meeting you in Groningen in 1913.

"Your friend, Professor Hamburger, has been

to see me at Liège last week. He told me of your splendid work and that the congress opens the first Tuesday in October, 1913.

"Yours very devotedly,

"LÉON FREDERICQ."

I publish this correspondence not simply because it authorizes me to publish under my own name an important contribution to the comparative physiology of the circulation, but, what I esteem far higher, it gives evidence of the high-minded manner in which men with warm, sane hearts adjust their differences. Too frequently we see men who claim extraordinary mental culture attack their confrères in a disingenuous manner calculated to injure their good name and self-respect.

The correspondence with Professor Fredericq illustrates how leaders of thought in natural science, if they are true lovers of science, will naturally observe the "Golden Rule."

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Among the alumni elected to official positions at the last meeting of the Medical and Chirurgical Faculty are:

President—Dr. Archibald Cunningham Harrison, class of 1887, of Baltimore, Md.

Vice-President — Dr. Charles Fitzsimmons Davidson, class of 1888, of Easton, Md.

Alternate to American Medical Association—Dr. William Royal Stokes, class of 1891, of Baltimore, Md.

Councillors—Dr. Josiah Slicer Bowen, class of 1903, of Mt. Washington, Md., and Dr. Guy Steele, class of 1897, of Cambridge, Md.

Committee on Scientific Work—Dr. Arthur Marriott Shipley, class of 1902, of Baltimore, Md.

Library Committee—Dr. John Whitridge Williams, class of 1888; Dr. Ridgeley Brown Warfield, class of 1884, and Dr. Carey Breckinridge Gamble, Jr., class of 1887, all of Baltimore.

Trustee Finney Fund for Three Years—Dr. Samuel T. Earle, Jr., class of 1870, of Baltimore.

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We would be glad to know the present locations of Dr. Max Joseph Fiery, class of 1910; Dr. Frank Paul Firey, class of 1910; Dr. Lafayette Lake, class of 1906; Dr. Eugene B. Howle, class of 1910, and Dr. John Edgar Rooks, class of 1905.

## THE FUNCTIONS OF AN ALUMNI ASSOCIATION.\*

By WILLIAM HERBERT PEARCE, M.D., '91.

*Mr. President, Ladies and Gentlemen*—When I received the invitation extended me by the Chairman of your Committee, Mr. Baker, to respond to a toast on this occasion, I was embarrassed by its flattering character.

After the initial intoxication of this signal honor had subsided, however, I began to ask myself what it all meant. Why should I be asked to address Dickinson Alumni? I am not a graduate of Dickinson; I never got out of her Prep. School. Like Ben Tillman, I am a product of the cornfield. The feeling that there was a sinister motive back of this flattering honor haunted me. I found myself vacillating between gratulation and apprehension—one moment gloating over the realization of a long cherished ambition, and the next, crouching with fear at the forebodings of an evil omen. For a moment, when buoyed up by the hope of preferment, I recalled President Woodrow Wilson's declaration that the most interesting men he had ever met were not college graduates. Then those words of Darwin came to me—"I barely escaped the blighting influence of Cambridge." And I thought of Herbert Spencer—the supreme man of our age—who refused to subject his imperial intellect to the levelling influence of college routine, and foreordained conformity.

In this state of exaltation I said, "At last the colleges are beginning to recognize merit outside their fold." This period of hopefulness was short-lived, and I again sank into the slough of despond, concluding I had been tricked. In sheer desperation I went to my old friend, Dr. Taneyhill—that incomparable generalissimo of confused situations—and pleaded with him to reveal the secret that actuated his committee, and this is what he told me: "You know," said he, "the Alumni of Dickinson College, as a class, are so given to self-depreciation and to such excesses of modesty that both they and their Alma Mater have suffered as a consequence. The graduates of other colleges, Harvard, Yale, Princeton, Columbia, Hopkins, Chicago, and all the rest, are so proud of their respective Alma Maters that in

their attitude toward each other and the world they display the most disdainful hauteur. "Not so with the Alumni of Dickinson," he continued, "they disparage their own achievements—depreciate their own motives, and discredit their own professions." When I inquired how he accounted for this anomalous situation he replied, "You know association begets assimilation, and we attribute it to the modesty of Dickinson's President. Now, in order to remedy this defect in the character of our Alumni, our Committee suggested asking you, for the sake of contrast, to speak with real bona fide Alumni, that they might furnish an object lesson in the great advantages that accrue to our graduates, whereby they hoped to inspire in the modest sons of this noble Mother, a laudable pride both in her and in themselves." "Then," said I, "your proposal is to make a fool of me in order to create a grateful consciousness in your Alumni." "Exactly so," said he; "we believed you to be a man of benevolent impulses, and surely there can be nothing worthier than the sacrifice of one's self for the happiness of others." When I protested that I had had no experience in making a fool of myself—since I got married—and did not know how to proceed, he replied, "Be natural." This, ladies and gentlemen, explains why an undergraduate Prep. is inflicted upon you tonight.

While it is true that I never got out of the Prep. School, I am free to confess that two boyish dreams overshadowed every other ambition that crossed my youthful pathway. One was to become a graduate of Dickinson, and the other, to be a Methodist preacher. Both of these worthy ambitions were traceable to a devoted Mother, who was as noble in character as she was exalted in her aspiration for me. When a mere child she took me to the Methodist Church and held up to me as models those preachers who had been trained at Dickinson. Well do I recall her admiration for George Bacon and Fred Heisse. They were, to my childish imagination, the Bossuet and Massillon of the American pulpit. But a fuller appreciation of the transcendent thaumaturgical power of Dickinson was realized at a later period. Though still a small boy, well do I remember when the distinguished President of your Baltimore Association—Dr. Wilbur M. Pearce, went to college. I had known him as the son of a farmer, and had always thought of him

\*An address delivered at the annual banquet of the Dickinson College Alumni Association, February 11, 1910, at the Hotel Rennert, Baltimore, Md.



as belonging to a similar sphere to that in which I had been born. He went forth from among us a typical country lad, and you can imagine my surprise, amazement and consternation when, two years later, he returned caparisoned in all the habiliments of the ultra-fashionable, draped in a long-tailed broadcloth coat, and crowned with a stove-pipe hat—not made to shine—but shining himself in a mannerism that would have put to shame Beau Brummel, or Harry Lehr. As I gazed upon his resplendent form, I said to myself, "Great is Dickinson!" I was unsophisticated enough to believe that this external transformation had been accompanied by a corresponding internal metamorphosis. Is it surprising that Dickinson should have become for me the hub of the universe? To Dickinson I determined to go.

I landed in the Prep. School just before President Reed made his debut in Carlisle. I shall never forget my first impression of the new President. In after life there are but few things more amusing than the first impressions of our juvenile period. I can better convey to you, perhaps, this juvenile idea by an illustration, rather than a description. Dr. Johnson, the great Sultan of English literature, was once standing on a street corner in London, conversing with David Garrick, the celebrated actor, when Bishop Horsley drove by with gay and brilliant equipage, that flashed and spun; whereupon Garrick remarked: "There goes Bishop Horsley, looking as though he might say to one of the Apostles, 'Here, Sir, hold my horses.'"

Shortly after Dr. Reed's arrival in Carlisle it was announced that standards were to be raised, and that only men of large mental calibre would be able to measure up to the new requirements. The wisdom of my withdrawal was hinted at, and finally a committee of commiseration waited upon me and advised me to discontinue my studies, and return to the farm, adding that I was wasting both my time and my father's money. In extenuation, they further suggested that I become an agricultural specialist, "For," said they, "it is evident that Nature has better equipped you for gathering apples than picking potato-bugs."

The toast to which I am to respond is, The Functions of an Alumni Association. While it is true that I have no Collegiate Mother, I have a Medical Mother, and from my relationships to her have been derived those experiences

that form that basis of my remarks. When we reflect upon the debt of gratitude that each of us owe our Alma Mater it seems strange to suggest that we need a memorial of her; and yet this is the most important function of an Alumni Association. We are ever prone to forget—to forget the best things of life. Even Jesus of Nazareth found it necessary to leave a memorial of Himself to His disciples. In reference to the Holy Eucharist, He said, "This do in remembrance of Me."

Bernard Shaw, in his great drama of Caesar and Cleopatra, in the farewell scene, makes Caesar forget even the all-conquering Cleopatra. The profoundest emotions that stir the soul of man are soon forgotten.

"Never a tear bedims the eye,  
That time and patience will not dry."

It is necessary, in order to preserve the most priceless things in life, in some way to memorialize them. To appreciate the importance of a Memorial to our Alma Mater, one has but to reflect upon the inspiring influence that great teachers make upon our whole career. Who shall measure the influence of such men as Werner at Freiburg, Dollinger at Munich, Arnold at Rugby, Tappan at Ann Arbor, Hopkins at Williamstown, White at Ithaca, and Agassiz at Cambridge.

Mr. Emerson, in writing to his daughter, said, "It makes little difference what your studies are, it all lies in who your teacher is." President David Starr Jordan says, "In my own education nothing meant so much to me as contact with a few great men whom I knew face to face." These words of President Jordan are a rehearsal of a chapter of my own experience. When I entered the halls of my Alma Mater, eyes I had, but saw not—ears, but heard not, and on my slumberous soul rested the weary weight of all this unintelligible world. I knew not the power of harmony and the deep power of joy that reveal the life of things, until my heart had been fired to flame by the concentrated influences of my Alma Mater. Within her sacred walls I had a new birth—an intellectual renaissance; aye, the conscious palingenesis of my whole psychic being; here my soul began to expand like a flower opening to the light. Through her I was admitted to the arcana of Nature—made to feel a kinship with the remotest star, and at home with the journeying winds. The horizon of my certainties was widened and separated by a firmer line

from the impalpable obscure that surrounds us on every side. To her I owe the inspiration of all those swirling eddies of thought that have engulfed my eager spirit in the lure of the Questioning Infinite that bends over us and throbs about us. From her—

\* \* \* "I have learned

To look on Nature, not as in the hour  
Of thoughtless youth; but hearing oftentimes  
The still sad music of humanity."

The second function of an Alumni Association is the advancement of the interests of our Alma Mater. There are relatively few Alumni that are able to make financial contributions to their Alma Mater, but it is in the power of every Alumnus to render her valuable service. Mr. Beecher once said, "There comes a time in every man's life when nothing can take the place of friends." This statement is just as true when applied to institutions as it is to individuals.

A word of commendation or an expression of confidence not infrequently yields large returns. I personally feel that a plea for Dickinson College can be made upon the highest possible grounds. So far as I know, she has not a James, or a Royce, a Dewey, or a Giddings, a Newcombe, or a Gildersleeve; but she has an asset more valuable than each or all of these to the formative period of youth, and that is an atmosphere of morality more distinctive than that of the Universities manned by these great teachers. We live in an age that is insane on the subject of intellectual education, and one that almost wholly ignores that which is of infinitely greater importance—moral discipline. Herbert Spencer acutely observes, "The intellect is but the servant—the emotions are the masters." The need of the hour is discipline of the feelings—we are fast becoming a nation of neurasthenics. Support your Alma Mater—her atmosphere has moral tone.

A third function of an Alumni Association is the preservation of the friendships of our student days. It is not without valid reason that the friendships of this period should be guarded more carefully than that of any other. All of the true, permanent and unselfish friendships of life are formed in youth. In the attachments of a later period we cannot avoid the alloy of selfishness. I care not how much certain personalities may attract us, it is impossible to exclude from

consciousness the idea of reciprocity. It is only in the joyous exuberance of youth that our spirits unconsciously respond to all that is best in the yearnings of kindred natures. Our college days not only constitute the period when the stable friendships of life are formed, but they furnish also the conditions most favorable for the growth of genuine attachments.

In Agassiz's eulogy of Humboldt he gives an impressive account of the influence that trained men exert upon each other. "What a rendezvous for the initiated was Agassiz's own chamber in the University of Munich! Here in one room was a museum, a laboratory, a library, a bedroom, a dining-room, and a fencing-room. Professors and students alike called it "The little Academy." Here they worked and talked and thought, sharing not alone the discoveries of the mind, but dividing also, with cheerful generosity, their scant meals and slender earnings.

The friendships cemented in college life alone are a sufficient justification for its existence. President Jordan well says, "In college you find the men you trust in after life, and one who does not fail you then will never after give you cause for regret."

The fourth and last function of an Alumni Association I shall enumerate is keeping alive the college spirit. There is among college men an esprit de corps that we call college spirit, which is produced by the distinctive atmosphere of college life. Four hundred years ago, in the old University of Greifswald, Ulrich Von Hutton defined the college spirit as "Gemeingeist unter freien Geistern," comradeship among free spirits. Comradeship embraces the intimacy of friendly relations, and implies the pursuit of similar activities. The word in its derivation denotes chamber-mate—the living, as it were, a common life. It is in the intimacy of human intercourse that the highest values of life inhere.

George Eliot, in writing to a friend, says: "There is nothing half so sweet in life as the delicious new friendship I have formed for Mr. Herbert Spencer; we have a delightful camaraderie in everything." The college spirit is more than comradeship; it is comradeship among free spirits. The true picture of the college spirit is that of co-workers sedulously searching for truth; for it is knowledge of the truth that makes free. "Ye shall know the truth, and the truth shall make you free," said Jesus. Is it not in

freedom from ignorance, selfishness and vice that we find abundance of life? Is there not need in the world of this college spirit? The mission of the scholar is not in seclusion, but in the currents of life.

Though the avenues of after life lead in diverging directions, it is possible through Alumni Associations and annual reunions to cherish the memory and advance the interests of our Alma Mater—to preserve the friendships of our student days—to keep alive the college spirit, and in sweet memory to tread again the paths we loved so well in the long ago.

"Each fainter trace that memory holds,  
So darkly of departed years,  
In one broad glance the soul beholds,  
And all that was, at once appears."

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\*PELLAGRA.

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EDW. A. LOOPER, *Senior Student.*

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The first authentic description of pellagra was made in 1762 by Gaspar Casal, a Spanish physician, who gave it the name of *Mal de la Rosa*. As early as 1735 he observed this peculiar affection among the peasants of the Asturias, but his writings were not published until after his death in 1762, by Joseph Gracia.

Trapolli of Milan is credited with having given the disease its present name, in 1771, pellagra (*Ital. pelle, skin; agra, rough.*)

From the articles of the long list of authors from that time down to the present the progress of the disease can be traced throughout Europe, from Spain to Southern France, from Italy to Upper Egypt, in parts of Africa, Austria, Servia, Bulgaria, India, Mexico, Barbadoes and certain areas of North and South America. Italy seems to have suffered more from the ravages of the disease than any of the other European countries. At one time it was estimated that one in every nineteen of the inhabitants in Northern and Central Italy suffered with the disease.

Pellagra has been known to exist in the United States less than 30 years, but its increase has been so rapid and prevalence so far reaching that it has become one of the gravest problems in the South today. Cases have been reported in 30 States of the Union, with the greatest num-

bers in Georgia, North and South Carolina, Kentucky and Tennessee, where the warm climate undoubtedly plays a prominent part in its greater prevalence.

*Etiology.*—The cause of pellagra has as yet not been definitely determined; however, several theories have been projected, the older of which is the Zeistic theory, whose adherents claim that damaged maize is in some way responsible for the malady.

Neusser contends that the poisonous principle is toxico-infectious in character, and is developed by the action of the bacterium *maidis* upon damaged or fermented maize.

Lombroso claims to have produced similar symptoms to pellagra, experimentally, in animals by injecting them with a toxine produced by the action of certain fungi and *aspergilli* upon fermented maize.

Much evidence has been given for and against the Zeistic theory, but at present it is undoubtedly losing ground, becoming supplanted by the idea that the disease is due to a specific parasite.

In 1910 Lombroso reported that his experiments and researches in Italy had led him to believe that pellagra was caused by the sand-fly or buffalo-gnat, and was a definite parasitic disease. His theory is based upon several important facts and has gained many adherents.

Mizell, in 1911, formulated the theory that a cotton-seed poison was responsible for the infection, and produced its effects by nutritional disturbances. Whatever the exciting cause may be, it is an indisputable fact that the impoverished condition of large masses of people, poor hygienic surroundings, alcoholic excesses and exposure to the sun's rays, are undoubtedly important predisposing factors. Any age may be affected, but most cases have been reported in adult life from the third to the fifth decade. In America women have seemed more susceptible than men. The first manifestation of the disease is usually in the spring months. The warmer climates afford the principal territories for greatest development of the disease. Pellagra is certainly not infectious, contagious nor inherited.

*Symptoms.*—There are two varieties of pellagra, the acute and chronic form; the latter is the common variety, and the one usually described.

The symptoms may be divided according to the systems most generally affected, viz.: dis-

turbances in the gastro-intestinal tract and cerebro-spinal system, and the characteristic skin manifestations, erythemato-squamous and pigmentary in character.

The appearance of the disease is usually in the spring months, the onset being insidious, and frequently preceded for several weeks by a prodromal period in which the patient experiences an increasing sensation of languor and general malaise, followed by increasing weakness and loss of interest in things, with neglect of customary duties and dread of exertion.

The first complaint is usually of some gastro-intestinal disturbance, which may manifest itself by anorexia, burning sensation in epigastrium, excessive desire for drink, and often an associated diarrhea, stomatitis and not infrequently excessive secretion of saliva simulating ptyalism. The tongue may be red and coated, with prominent papillae. Nausea and vomiting is apt to ensue.

Tenderness along the spine and pain in the back is frequently complained of. The temperature may remain normal through the disease, but cases have been reported where the temperature was subnormal, and in others it ran from 102°-108°. The pulse is usually elevated from 80-160. The diarrhea is characteristically obstinate, resisting all medication and dietary correctives.

The characteristic manifestations of pellagra are the cutaneous phenomena, which, according to Stelwagon, may be divided into three stages—the first, a congestion or erythema; the second, with added scaliness, thickening and pigmentation; and the third, a tendency to atrophic thinning.

The first stage of the eruption usually makes its appearance in the early spring, developing rather suddenly, with symmetrical distribution of an erythemato-squamous character, generally limited to the parts of the body exposed to the sun's rays. The entire face is often covered with a symmetrical distribution, producing the typical pellagra "mask," while an erythematous circlet around the neck, first described by Casal, is very characteristic.

The most common seat for the lesions are the backs of the hands, spreading from the ulnar to the radial sides, but sparing the nails and palms, and having a distinct line of demarcation at the cuff line. When the feet are similarly exposed they are usually affected in the same way. Oc-

asionally the genital region of both sexes may be affected.

The color of the erythema very closely resembles the appearance of the skin after ordinary sunburn, at first being a dull red, and later of dark brownish hue. The eruption may be dry or moist in character, and in the milder forms may desquamate in a few weeks in the form of fine scales.

It is common for the skin to become infiltrated, thickened and swollen, with burning, itching sensations, which may later result in anesthesia. The superficial or deeper layers of the skin may be the seat of the inflammation. After a short while the epidermis exfoliates, leaving the underlying surfaces red and frequently fissured, greatly resembling a first degree burn.

Pigmentation takes place with each and succeeding attacks, and with the deep infiltration leaves the organs covered with a corded, irregularly roughened epidermis, which has given the disease its distinctive title of "rough skin." With the appearance of winter the cutaneous eruptions usually show improvement, only to have a recrudescence in the following spring.

After repeated attacks the skin becomes wrinkled, thickened and lax, and takes on a senile appearance, presenting a bluish red or dark brown color, with a tendency to exfoliate in flakes (Stelwagon).

The inflammation affects the mucous membranes as well, giving the cardinal red color to the buccal cavity, with similar changes in the rectum.

The nervous manifestations of pellagra, which at first were betrayed by headache, vertigo, tremor and lassitude in the early stages of the disease, become progressively worse, often resulting in profound mental depression, occasionally in a settled melancholia, which may be interrupted by periods of illusions and hallucinations, and often followed by stupor. These symptoms may continue until the patient is profoundly prostrated, with resulting death from emaciation, or the course may be more chronic, terminating in true pellagrous insanity.

However, insanity is not as frequent a complication as is generally considered, for according to the Dunning Report of Pellagra in Italy only 10 per cent. of the patients of that country become insane.

*Prognosis.*—The prognosis of pellagra is at

best very grave, although in countries where the disease is endemic, and in mild attacks, the outlook is fairly favorable. In the severe cases the average duration of cases is five years, but it may continue for 10 or 15 years.

Most of the cases in the South are of the acute variety, generally proving fatal within a shorter duration.

*Treatment.*—As our knowledge in regard to the etiology of the disease is indefinite, we cannot exercise proper prophylactic precautions, but we can profit by the example given us by the Italian Government, where they have shown that prophylactic measures can reduce the prevalence wonderfully. They have accomplished their brilliant results by elevating the hygienic environment of the poorer classes and excluding damaged maize from the dietary of their peasantry. Laws have been enacted for the inspection and condemnation of suspected food products, and compelling the authorities to report all pellagrous patients. Commissions have been formulated to further study the disease, institutions have been founded for the care of the sick, and modern "dietary kitchens" have been established in the poverty-stricken districts, with the result of an enormous decrease in the number of cases in that country.

Whether damaged maize is or is not responsible for the disease in this country, scientific men have assigned enough value to its relation to pellagra for the National Pellagra Conference, held in Columbia (1909), to declare: "That while corn is in no way connected with pellagra, evidences of the relation between the use of spoiled corn and the prevalence of pellagra seem so apparent that we advise the continued and systematic study of the subject, and in the meantime we commend to corn growers the great importance of fully maturing corn on the stalk before cutting the same."

The medicinal treatment of the disease is disappointing. No specific remedies have been found. The hope of improvement lies in placing the patient under good hygienic surroundings and improving the general health by good food and such tonics as are indicated. Arsenic, in the form of Fowler's solution, and the iron preparations have been principally used, with good results at times. Atoxyl, quinine and strychnine have been recommended.

Cole and Wintrop have reported success by

transfusing blood in a few individuals. Salvarsan has been tried recently, with evident improvement in the symptoms of the few cases reported.

#### A CASE OF CEREBRAL LUETIC ENDARTERITIS WITH A TEMPORARY OCCLUSION OF A LOWER ANTERIOR BRANCH OF THE MIDDLE CEREBRAL ARTERY, CAUSING A TEMPORARY ANEMIA OF BROCA'S CONVOLUTION.

By MILFORD HENXANT and HENDERSON IRWIN,  
*Senior Medical Students.*

This case, which was treated at the University of Maryland Hospital, is a typical case with many of the characteristic symptoms.

*Name*—W. T. C.

*Address*—

*Occupation*—Foreman on Railroad.

*Age*—Thirty-eight years.

*Sex*—Male.

*Race*—White.

*Social Condition*—Single.

*Chief Complaint*—Disturbance of speech. In the words of patient he has "trouble in speaking and in using my right hand properly."

*Family History*—Mental troubles negative. Patient's mother is nervous and excitable at times; negative to drug habits; constitutional inheritances, so far as tuberculosis, syphilis, nephritis, cardiac diseases and malignancy, is negative.

*Previous Medical History*—During childhood he had nothing except whooping cough. His adolescent stage was uneventful as to any medical conditions. Since reaching the adult stage the patient has been very strong and healthy, except for an occasional attack of indigestion, for which he was treated by a physician. For the past three months he has been suffering with headache and dizzy spells, for which he was also treated; the nature of this treatment could not be obtained.

*Present Illness*—The patient's trouble began by having a constant headache, numbness at times (which was almost constant) of the right arm, forearm and fingers, and peculiar sensations in the right side of the face. His vision was only slightly disturbed.

On July 6 the patient was advised to go for a little outing to see if the fresh air would prove

beneficial. The patient went to Curtis Bay, and after being there for about two hours, he began to feel as if he were going to faint. He had no pain, but realized that he was getting weak and felt very queer. He then went to a friend's house and very soon afterwards he could not talk, and tried to write, but all he could do was to make a few signs. He was perfectly conscious of his surroundings but could not express himself. At the same time he lost the entire use of his right arm and hand.

*Physical Examination*—Thorax, well formed, lung expansion equal on both sides; palpation and percussion negative; auscultation, normal respiratory sounds. Heart inspection, P. M. I. in fifth interspace in mid-nipple line; palpation confirms inspection; percussion, area of cardiac dullness normal; auscultation, over the apex there is a soft systolic flow; over the base there is a soft murmur; no appreciable accentuation of the second sound.

Abdomen soft; spleen not palpable; liver dullness normal; no masses to be felt, no hernia, no tenderness. Upper and lower extremities are very well formed and show no scars nor injury.

#### SPECIAL EXAMINATION.

*Head*, fair amount of brown hair; skin clear.

*Ears*, well-formed and in normal position, but a partial deafness exists on both sides.

*Eyes*, react to light and accommodation; area of vision diminished; slight retraction of both upper lids.

*Neck*, normal.

*Kidneys*, normal.

*Bladder*, normal.

*Blood*, leucocytes 14,605; hemaglobin 95, blood pressure 95, Wasserman reaction, positive.

*Urine*, reddish-amber color, a few epithelial cells, leucocytes and granular casts. Albumen and sugar negative; sp. gr. 1.030, reaction acid.

*Stomach contents*, normal.

*Spinal Fluid*—Leucocyte count 30 to a field, stained smear shows increase in leucocytes of small variety.

*Fundi of the Eyes*—Normal.

*Sputum*—Negative.

*Nervous Examination*—Intellect only fair; memory is poor; speech articulation is disturbed; speaks indistinctly; speech is thick. He recog-

nizes objects but it is difficult to articulate their names. Gait, normal; moves his limbs well.

*Motor Examination*—The right arm is weaker than the left. The grip of the right hand is weaker than that of the left. The motor power of the lower extremities is about equal. There is no tremor or spasm of any of the muscles of the body. The muscles of the right side of the face are weak. This is particularly marked in the buccinator.

Co-ordination of upper and lower extremities is not good, showing more disturbance of the right side than of the left.

Romberg's sign, positive.

Babinsky's sign, present in right foot. Negative in the left.

Kernig's sign, negative. Superficial reflexes increased.

Deep reflexes, knee reflexes increased on both sides. Tendo-Achilles increased on right side, normal on left. Periosto-radial and triceps more marked on left than on right side; no cervical rigidity; no spinal tenderness.

*Sensations*, tactile good, pain good, temperature good, muscular sensations fair.

*Treatment*.—The patient was admitted to the hospital at 8 P. M. on July 6; was given a purge and then strychnine gr. 1/60, morphia. gr. 1/10. He was given strychnine gr. 1/30 t. i. d. until July 15; at this time he was given nitro-glycerine gr. 1/100 and this was kept up until August 12.

On August 12 patient was discharged. His articulation was good; his face and hand were useful; he had a good color and the troubled face had given way to a pleasant expression and he was in good condition generally.

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Dr. William W. Braithwaite, class of 1909, sailed for Panama on the 23d. Dr. Braithwaite has been appointed to the Isthmian Canal Commission Hospital (550 beds) at Cristobal. He is a native of North Dakota, and lived for some time in Southern Maryland before coming to Baltimore and entering the University.

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Dr. Marshall Langdon Price, class of 1903, is a member of the recently-appointed Sanitation Commission, which will confer with a similar commission of the District of Columbia with reference to the disposal of sewage in the District and the sections of Maryland contiguous to the District.

## TECHNICAL AND SCIENTIFIC QUALIFICATIONS OF A TEACHER OF PHYSIOLOGY.

By JOHN C. HEMMETER,

*Member of the Deutsche Physiologische Gesellschaft; Professor of Physiology, University of Maryland.*

Our country was the only one in which it was legal to organize medical schools by an association of private individuals during the latter half of the last century. The result was an exuberance of so-called schools that were in reality stock companies organized by private practitioners with a view to benefiting either directly from the tuition fees or indirectly from consultation work brought by students and graduates.

As medicine became more and more an exact science by the growth of anatomy, physiology, chemistry, pathology, bacteriology, it became evident to even the egotistical managers of what might without exaggeration be called "Commercial Medical Schools" that certain subjects were beyond the ability of the "physicians" as then educated, and they were compelled *volens volens* to elect specialists in chemistry—men who had obtained the degree of Doctor of Philosophy in one of our foremost endowed universities by a thorough and intensive study and research work in chemistry. This was a step forward, but physiology was still taught largely in a dilettantish, amateurish way by practitioners who had no special, or at best only a very superficial, training in physiology.

Chemistry is not a science that is based on many adjuvant or collateral branches of human knowledge—a preliminary A.B. in a good college apparently still equips a man to enter on this spectral study. But physiology demands of its devotees a thorough training in numerous other independent sciences. Chemistry is a structure of human knowledge self-sufficient in itself; perhaps physics may be considered as an adjuvant science indispensable to an understanding of chemistry. Physiology—the science of the regular processes that go on in living things—requires a preliminary training in chemistry, physics, botany, general biology and anatomy.

To be a physiologist a teacher must make himself an expert in hundreds of little and major operations where the instrumental technique—the

asepsis and the knowledge of anatomy—indicate whether a teacher is a dilettante or a trained experienced physiologist.

In addition, the science of life has in the last 20 or 25 years been so enormously extended, such a wealth of literature has accumulated and is constantly being added to, that unless a teacher speaks, reads and writes at least three modern languages it is almost impossible to keep abreast of the progress of his own time in the advances that are made.

Personally, I have found that my own course in physiology requires readjusting and remodeling every year, so that my system of physiologic discipline has not been alike in any two years, and it would be fatal to inculcate into the mind of any class of students that such a course could be so given that all lectures, demonstrations and conferences would be exactly alike in two consecutive years, for to them this would soon mean that the science had stood still, and that means stagnation. A teacher must never cease occupying himself with one research or another if he desires to be a true university teacher, for only as a research worker can he gain a deep insight into the whole biochemic and biophysics driving mechanism of the living substance.

Strange as it may seem, the absorbing interest and training in clinical medicine exceedingly rarely fits a man for the teaching of physiology, whereas a training of exhaustive thoroughness in physiology is the best preparation imaginable for the clinician. The reason for this divergent mutual utility between clinical medicine and physiology is to be sought in the fact that only exact and objective sciences can be fundamental to other sciences. And medicine is not an exact science. But physiology is becoming one of the most exact and objective sciences that the human mind has formulated; it postulates absolute emancipation from the intuitive and imaginative functions of the mind and unconditional submission to the hard yoke of objective investigation. A kind of mind that is only exceptionally and exceedingly rarely developed by a medical training.

The period during which the medical faculty could appoint practitioners of medicine to fill the positions of teachers in physiology has passed 20 years ago. It is just as impossible for a practitioner of medicine to teach physiology as it is for him to satisfactorily fill the chair of chemistry. A highly-specialized physiologic technique has

become indispensable, in addition to the thorough grounding in the facts, doctrines and hypotheses of the science itself, and to have physiology taught by one who by habit is accustomed to thinking only clinically gives physiologic science a twist and warp in the hands of such a man which distorts its aim and makes true understanding of the normal processes of life practically impossible. From *Old Maryland* for May, 1907, p. 66, we quote the following: "In order to have physiology taught in the highest and most skilful manner, Dr. and Mrs. J. C. Hemmeter have made an agreement with the trustees of the Endowment Fund of the University of Maryland, which was made in 1907. The following extract is taken from this agreement as it appeared in *Old Maryland* for May, 1907, p. 66:

"In beginning an Endowment for a Chair of Physiology in the University of Maryland, Prof. and Mrs. John C. Hemmeter 'recommend and request' that the Board of Trustees observe the following conditions: 'The first installment of \$1500, together with future yearly contributions and such legacies as will be bequeathed for this same purpose, are to be kept at interest until the principal has accumulated sufficiently to yield a salary of at least \$3000 annually to the professor holding the chair at the time when this amount shall have accumulated.

"If at that period a larger salary is required for a professor, the \$3000 annually accumulating from this fund may nevertheless be utilized for this purpose, provided the administrative body of the University of Maryland at that time agrees to supply the difference' needed to complete the amount required.

"It is urgently desired that the benefits accruing from this fund shall not be available or granted to any teacher who is not a *trained physiologist*. By that we mean that he must have made a special study of physiology for at least four years in the laboratories of physiology of one or other of our larger universities, such as Harvard, Yale or Columbia or the City of New York.

"We distinctly desire to have it understood that the benefits from this fund are not to be granted to teachers who simply have a degree in medicine only, and have no special training in physiology. What we understand by special training is defined in the preceding. The object of this is to make the teaching of physiology more

and more objective, and not to depend upon lectures exclusively, but more upon laboratory work.

"In awarding the professorship it is our desire that candidates who are born and educated in this State, and particularly alumni of this University, shall be given the preference; but if none such can be found who have gone through special training either in Europe or in the large universities of this country, candidates from any State or nationality may be selected."

"The founders of this fund do not state the amount it is their intention to give to it, but declare that provision will be made in their wills for its increase. The fund now amounts to \$5400." The founders of this fund should insist upon the conditions of high and exclusive scholarship, technical training and ability, together with a broad experience. For broad experience, conservative yet penetrating critical judgment, a fanatical enthusiasm for truth and exactness, together with a warm, sane heart, are qualifications *sine qua non* in physiologic discipline. The thought may occur why medical men are to be excluded from the chair of physiology, since the writer is himself a clinician. It is because of this very fact that he is best able to realize his own shortcomings as a teacher of physiology, and that as far as the University of Maryland is concerned, the list of clinician physiologists will end when his activity in that chair ends. His successor will be a trained physiologist pure and simple, and the days of the last Medical Mobian in that science are come when he terminates his connection with this University.

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Governor Goldsborough has appointed the following alumni as coroners:

Northern District—Dr. Henry C. Algire, class of 1895, of 3640 Roland avenue. Dr. Algire is 37 years of age and a native of Baltimore. He succeeds Dr. G. Milton Linthicum.

At Large—Dr. Henry C. Hyde, class of 1899, of 1024 E. North avenue. Dr. Hyde is a native of Baltimore and is 43 years of age. He is a lecturer on pathology and bacteriology in the University of Maryland.

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Dr. J. Burr Piggott, class of 1907, is now located at the Thomas, 1400 M street N. W., Washington, D. C.



# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, MAY 15, 1912.

"WE HAVE PIPED UNTO YOU, AND YE  
HAVE NOT DANCED."

The above quotation about expresses the situation in regard to the pathological endowment fund. We have called unto you, and you have not responded. We have piped in dulcet tones, and you have not jigged. Ross R. Winans, a recluse and misanthrope, died recently in this city. His estate is supposed to be worth about \$4,000,000, and was left to relatives and friends. Not one cent was left to charitable or philanthropic institutions. A half million dollars was left to a fine young woman at Newport, R. I., who had been attentive to him when he was ailing. We congratulate her on her good fortune. A man has the right to dispose of his property in accordance with his own wishes, but one would think he would rest more comfortably if he had left something to the unfortunate and suffering. Dr. Pearsons of Chicago died recently at a very advanced age and left scarcely enough to give himself a decent burial. During his lifetime he gave away all his property to small and needy colleges; his benefactions amounting to several million dollars. He certainly chose the better part. Medical schools must have money more than can be obtained from students' fees. What a Godsend \$500,000 would be to us! However, we are not proud. If you can't give that amount, we would be pleased to have contributions of \$25

each from our Alumni. Don't wait until you are dead, *give now*.

## CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1868.....	10 00
1871.....	35 00
1872.....	70 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	35 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	15 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	25 00
1900.....	215 00
1901.....	175 00
1902.....	305 00
1903.....	300 00
1904.....	145 00
1905.....	200 00
1906.....	130 00
1907.....	110 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino-Americano.....	25 00

Total subscription to May 1, 1912..\$9895 50

## SUBSCRIPTIONS IN APRIL.

Dr. Joseph T. Smith, 1872 (second contribution).....	\$5 00
Dr. Walter S. Phillips, 1897.....	10 00
Dr. John A. Tompkins, Jr., 1898.....	25 00
Dr. Arthur J. Edwards, 1899.....	25 00
Dr. C. B. Williams, W. Va.....	25 00

Additions for the month..... \$90 00

## ABSTRACT

In a very instructive article on "Cartilaginous Tumors of the Larynx" (*Annals of Otology, Rhinology and Laryngology*, December, 1911), Dr. James J. Carroll, class of 1893, of Baltimore, after reviewing the literature on the subject, reports the following case, which came under his observation in October, 1907, and which has not been reported previously:

L. J. T., white, single, 34 years old, a railroad engineer, had always enjoyed good health until he contracted lues in 1904 and had both primary and secondary lesions. Patient took antisyphilitic treatment for a year, after which he stopped the medicine because he was free from symptoms. Four months before coming under observation patient began to get hoarse, the hoarseness gradually giving way to aphonia. About a month after the hoarseness came on he began to have some difficulty in breathing, and two months later he noticed an enlargement of his throat in the region of the larynx. He came to St. Joseph's Hospital, October 26, 1907, to find out the cause of his hoarseness. Examination showed the patient to be in excellent physical condition, all organs normal except the larynx. He was aphonic and had some difficulty in breathing, which was aggravated by the recumbent position and by walking. He had a short, quick, metallic cough, which was made worse by lying down. There was no difficulty nor pain upon swallowing. Exteriorly there was a swelling over the thyroid cartilage on the left side. No glandular enlargements were felt in the neck. Laryngoscope showed a large rose colored subglottic tumor. Its surface was even, smooth, clean and free from ulceration. It lay just under the vocal cords, attached loosely to the under surface of the posterior half of the right cord and firmly connected with the posterior two-thirds of the left cord. The apex was free, rounded, and came within 5 or 6 mm. of touching the anterior wall below the commissure. The base was attached to the posterior wall and to a slight degree to the lateral walls. The right cord was congested and moved pretty freely, but not entirely to the middle line. The anterior third of the left cord was free from congestion, but the cord itself was fixed to the side of the larynx. The right arytenoid moved freely on attempt at phonation, but the left had only a slight motion, of a rotary character, with no approximation to

the median line. There was a little thin mucus about the laryngeal cavity, but no muco-purulent secretion. A few drops of cocain and adrenalin, injected into the larynx, made no change in size or contour of the tumor. A radiograph taken by Dr. H. Ashbury showed very clearly a more or less circular shadow, the upper boundary of which was about on a level with the middle horizontal plane of the thyroid cartilage, and the lower boundary fell a little below the ring of the cricoid. The anterior border was free, while posteriorly the shadow of the tumor was continuous with the shadow of the cricoid plate.

As the patient had had syphilis, he was put on antiluetic treatment for a month, although the larynx did not present a picture which in any way resembled the usual syphilitic lesions of the larynx. The growth was also not malignant in appearance. Of the benign tumors it suggested most strongly a chondroma or an internal struma. A positive diagnosis between these two was not ventured without a histologic examination. The patient was exhibited before the Rhino-Laryngological Section of the Baltimore City Medical Society, November 29, 1907.

The large size of the tumor and its position below the cords precluded the possibility of removing it by an endolaryngeal operation; the external operation was therefore decided upon. A preliminary tracheotomy through the third ring was done on December 11, 1907. On the 14th laryngofissure was performed by the late Dr. I. R. Trimble, with the patient under chloroform. A vertical incision was made in the skin in the median line from the hyoid bone to the second ring of the trachea where it joined the tracheotomy wound. After the thyroid cartilage, the cricothyroid membrane and the cricoid cartilage were well exposed, a vertical section was made through the last two, exposing the lower part of the tumor. The growth filled almost the entire subglottic space, leaving only enough room between the apex of the tumor and the anterior commissure to pass a grooved director. The lower surface of the growth was smooth, pale red, slightly irregular and free from ulceration. To expose the mass satisfactorily the section had to be extended upwards through the entire thyroid cartilage, which was exceedingly hard to cut. With the sides of the thyroid cartilage pulled apart, ample room was obtained for manipulation. Laryngeal reflexes were abolished by cocain and the bleeding checked

by adrenalin. Tumor was quite firm to the touch. Its free border faced anteriorly and to the right, the attachment being posteriorly and along the left wall of the larynx. The enveloping membrane, largely mucous membrane, was opened at the apex. A grayish-white granular material oozed through this opening, not unlike boiled grits in appearance and consistency. The bulk of the tumor was removed with curette and most of the enveloping membrane with scalpel. After the use of the curette the plate of the cricoid was seen denuded of mucous membrane and perichondrium. The exact site of the growth was the left half of the cricoid plate, the posterior half of the cricothyroid membrane and the adjacent thyroid cartilage. The origin was evidently from the cricoid, the thyroid being affected by extension. The tumor was as large as a medium-sized English walnut, measuring about an inch in both vertical and horizontal diameters. Its upper surface under the cords was more flattened than the lower facing the trachea. In closing the wound the sides of the thyroid cartilage were brought together with silver wire. The cricoid ring was not sutured and the tracheotomy tube was brought up from the tracheotomy wound and inserted here, the original wound in the trachea being allowed to close. The tube caused a good deal of pain and cough, and was removed on the second day after the operation. Wound was firmly healed on the twentieth day. Patient recovered with a much-improved voice, good easy breathing and no cough. Perfect vocal function could not be expected on account of the unavoidable destruction of a good part of the left cord. At this writing there is no evidence of recurrence. A histologic examination of the tumor was made by Dr. E. H. Hayward, whose report is as follows:

"The specimen consists of several small fragments of tissue, pink in color and of the consistency of muscle. There is no evidence of any old calcareous deposits on cutting the prepared specimen. Histologically there is seen a groundwork of material similar in structure to hyaline cartilage. Scattered throughout this are irregular nests of cartilage cells, many spindle-shaped fibrous tissue cells, areas of myxomatous degeneration with fairly numerous stellate cells, and some small calcareous deposits. The most numerous and characteristic elements are the cartilage cells. They are rather atypical and show no regularity in arrangement. They are collected in scattered

masses, separated by immature fibrous tissue and by elements of degeneration. Many of the cells are without capsules."

He concludes his article as follows:

1. There should be uniformity of nomenclature. The term *enchondroma* should retain the meaning given it by Virchow, and should not be applied to growths of the larynx, these being either *chondroma*, *ecchondroma*, *ecchondrosis* or mixed tumor.

2. *Ecchondroses* of the larynx should be regarded as overgrowths of cartilage, not real tumors.

3. Although *chondroma* has been known to recur, and even to metastasize, it is not an invasive neoplasm in the broad sense of the term, and should be looked upon rather as benign than malignant.

4. Although the clinical aspect of the disease is quite definite, the etiology is still much in doubt. In 1888 Bruns said "cartilaginous tumors of the larynx are so rare that the study of every case is of the greatest value in order to establish the clinical course of the disease and to furnish data for proper therapeutic measures." The clinical course of the disease has been pretty clearly determined by the various cases published since Bruns' article. The histologic and pathologic phase of the subject has been well brought out by Alexander's work. The etiologic phase, however, lags behind and invites further work and careful investigation.

512 Professional Building.

## ITEMS

Dr. Robert Parke Bay, class of 1905, delivered an illustrated lecture on "Fractures" before the Howard County Medical Society at Ellicott City, March 19, 1912.

The following committee report was adopted at the meeting of the Alumni Advisory Council:

To the University of Maryland Alumni Advisory Council:

Gentlemen—We beg to submit for your consideration the following suggestions to be offered the Faculty of Physic.

(1) That it is the sense of this body that every effort be made and no sacrifice be considered too great to comply with the recent requirements of the American Association of Medical Schools,

calling for the establishment of four full-time professorships.

(2) That the inauguration of physical therapeutics as a separate lectureship is a timely innovation in the line of progress.

(3) That the effort to establish an endowment fund for the chair of pathology, inaugurated by Prof. Randolph Winslow, is worthy of highest commendation and merits earnest support.

(4) That in our opinion, no student should be admitted to the third year until all previous conditions shall have been met. We believe the percentage of failures at the State Board Examinations will thereby be materially reduced.

Respectfully submitted,

Signed: HARRY ADLER, Chairman,  
G. LANE TANEYHILL,  
JOSEPH GICHNER.

Dr. Arthur M. Shipley, class of 1902, has removed to 1827 Eutaw place, Baltimore, Md.

The members of the Adjunct Faculty of the Medical Department of the University of Maryland are:

Doctors—

J. R. Abercrombie, 827 N. Eutaw street.

J. F. Adams, 1316 N. Charles street.

H. A. Adler, 1904 Madison avenue.

H. E. Ashbury, 1029 Cathedral street.

Daniel Base, Pharmaceutical Department, University of Maryland.

Robert P. Bay, 1701 Guilford avenue.

Hugh Brent, 906 N. Calvert street.

Albert H. Carroll, 906 N. Calvert street.

Henry M. Chandlee, 742 W. North avenue.

William G. Clopton, 2611 E. Fayette street.

C. C. Conser, 1113 N. Fulton avenue.

J. M. Craighill, 1730 N. Charles street.

M. J. Cromwell, The Latrobe, Charles and Read streets.

H. C. Davis, 114 W. Franklin street.

S. De Marco, 1604 Linden avenue.

Page Edmunds, The Wentworth, Cathedral and Mulberry streets.

A. L. Fehsenfeld, Garrison and Fairview avenues.

George A. Fleming, 1018 Madison avenue.

John S. Fulton, 2211 St. Paul street.

E. E. Gibbons, 1102 W. Lafayette avenue.

Joseph E. Gichner, 1516 Madison avenue.

Thomas C. Gilchrist, Professional Building.

R. C. Harley, 1309 W. North avenue.

J. F. Hawkins, 1618 Light street.

George Hemmeter, 800 Harlem avenue.

Jose L. Hirsh, 1819 Linden avenue.

Joseph W. Holland, 1624 Linden avenue.

John Houff, 15 N. Monroe street.

J. Mason Hundley, 1009 Cathedral street.

H. C. Hyde, 1024 E. North avenue.

J. Knox Insley, 2938 E. Baltimore street.

John G. Jay, 817 N. Charles street.

Richard H. Johnston, 807 N. Charles street.

H. W. Jones, Augusta and Frederick avenues.

Leo Karlinsky, 1114 Chesapeake street.

G. S. M. Kieffer, Morrell Park.

Frank J. Kirby, 110 E. North avenue.

E. H. Kloman, 1619 St. Paul street.

F. Levinson.

G. C. Lochar, 1631 W. Lafayette avenue.

F. S. Lynn, 1619 St. Paul street.

Harry D. McCarty, 613 Park avenue.

Charles W. McElfresh, 1415 Linden avenue.

H. J. Maldeis, 437 E. 25th street.

Frank Martin, 1000 Cathedral street.

Wm. I. Messick, 1606 Madison avenue.

Roscoe C. Metzel, 1903 W. North avenue.

Robert L. Mitchell, 2112 Maryland avenue.

J. F. O'Mara, 1042 Edmondson avenue.

Elisha S. Perkins, The Rochambeau.

Oliver Parker Penning, 1711 St. Paul street.

William Queen, Arlington.

J. Dawson Reeder, 639 N. Fulton avenue.

Compton Riely, 2025 N. Charles street.

Harry M. Robinson, 2010 Wilkens avenue.

George M. Settle, 2435 Maryland avenue.

H. L. Sinkey, 1616 E. Baltimore street.

C. C. Smink, Lauraville, Md.

William F. Sowers, 2311 Edmondson avenue.

Irving J. Spear, 1870 Madison avenue.

St. Clair Spruill, 1002 Cathedral street.

J. H. Smith, Jr., 2205 St. Paul street.

Joseph T. Smith, The Cecil.

William H. Smith, 3429 Chestnut avenue.

H. W. Stoner, 2229 E. Federal street.

Wilbur Stubbs, 647 N. Calhoun street.

William Tarun, 613 Park avenue.

R. Tinstall Taylor, 2000 Maryland avenue.

G. Timberlake, Professional Building.

Homer U. Todd, 1027 N. Gilmor street.

J. A. Tompkins, Jr., 905 Cathedral street.

A. J. Underhill, 1812 N. Charles street.

A. DeT. Valk, Kernan Hospital.

Fred H. Vinup, 1221 Hollins street.

J. H. von Dreele, W. 36th street, Hampden.  
 William K. White, 1818 N. Charles street.  
 R. G. Willse, 1127 Madison avenue.  
 Gordon Wilson, 1318 N. Charles street.  
 John R. Winslow, The Latrobe, Charles and  
 Read streets.  
 Nathan Winslow, 3304 Walbrook avenue.  
 Hiram Woods, 842 Park avenue.

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The annual smoker given by the Adjunct Faculty to the Senior Medical Class will be held on Friday, May 24, at 8 P. M., in Davidge Hall, Lombard and Greene streets.

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The commencement of the University Hospital Training School for Nurses was held on Wednesday, May 15, 1912, at 8 P. M., at Lehmann's Hall, Baltimore.

The Program was as follows: Music. Prayer, Rev. Arthur B. Kinsolving, D.D. Music. Address to the Graduates, Randolph Winslow, A.M., M.D., LL.D. Music. Conferring of Diplomas, R. Dorsey Coale, Ph.D., Dean of the University. Music. Benediction.

Those who received diplomas were:

Mattie Estelle Coale, Maryland.  
 Agnes May Lynch, Florida.  
 Marion Campbell Smith, Maryland.  
 Alice Mand Wells, Canada.  
 Lucy Lee Harvey, Maryland.  
 Mary Juliette Miles, Maryland.  
 Eulalia Murray Cox, West Virginia.  
 Bernice Victoria Conner, Maryland.  
 Lena Elizabeth Stouffer, Maryland.  
 May Katherine Steiner, Maryland.  
 Eliza Nalley Ridgley, Maryland.  
 Ann Ethel Logue, Pennsylvania.  
 Lilian Freeman Blake, Maryland.  
 Blanche Louise Prince, Maryland.  
 Ethel Mayotta Dawson, Maryland.  
 Lucy Marian Lilly, Georgia.

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Dr. George Yellott Massenburg, class of 1911, formerly attached to the staff of the Church Home and Infirmary, has been appointed a resident surgeon in the Santo Tomas Hospital of Panama City, Panama.

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Dr. Anton G. Rytina, class of 1905, has removed to The Shirley, Baltimore.

The annual smoker of the General Alumni Association will be held Friday, May 31, in the hall of the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral street, Baltimore. Governor Goldsborough has promised to attend, subject to the contingencies of public business. Rev. Charles Fiske, rector of St. Michael's and All Angels' Protestant Episcopal Church, will speak, and Mr. Leroy Oldham will entertain with Southern songs and stories. The Bentztown Bard, Mr. Folger McKinsey, will also be one of the guests, and Dr. B. Merrill Hopkinson is arranging the musical program. Tickets are \$1, and are obtainable from Dr. Nathan Winslow, class of 1901, at 608 Professional Building.

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Prof. Hemmeter, who is himself an artist and composer, lectured to the students of the Peabody Conservatory of Music on April 18th on the *Physiologic Fundamentals of Piano Technique*. He has made this subject peculiarly his own, and according to the Peabody Conservatory faculty there is no one who can even remotely control it like our physiologist. He has received the following letter from Prof. Harold Randolph, the director at the Peabody Conservatory of Music.

"Dear Dr. Hemmeter:

"I have been so busy and harrassed with our Opera Class that until the performance was over I had neither sense nor memory. This alone can explain my delay in thanking you more fully for your most interesting and stimulating lecture.

"You brought out many points that were new to us and shed fresh light on many of the old ones upon which we have been harping for many years.

"I am sorry to think that any one—either a student or teacher—should have been prevented from hearing it.

"With warmest thanks from all of us,

"Very sincerely yours,

HAROLD RANDOLPH."

Prof. Hemmeter is considering an invitation to give three lectures on the same subject at the April 27, 1912, Cincinnati Conservatory of Music, and one lecture each on "*The Physiol. Fundamentals of the Human Voice in Speaking and Singing*," and on "*Rhythm and Harmony in Relation to Auditory and Brain Physiology*."

A Philadelphia publishing house has sent their

representative with a flattering offer to publish these investigations and studies on the borderline between music and physiology in book form.

Dr. John Guirley Misseldine, class of 1911, passed the Nebraska State Board medical examinations with third honors, and is practicing at Oxford, Neb.

Dr. Eugene Wright, class of 1908, is superintendent of the Church Home and Infirmary, Baltimore.

*Leslie's Weekly*, issue of April 4, 1912, shows a picture of the first intercollegiate baseball game of 1912, being the game played between the University of Maryland and the Naval Academy on March 20, 1912. The picture shows the grounds crowded with spectators.

Dr. Harry Montrose Slade, class of 1884, of Reisterstown, Md., was appointed health officer of Baltimore county, to succeed Dr. James F. H. Gorsuch, class of 1876, of Fork, Md.

The following alumni have been appointed district health officers of Baltimore county:

First District—Dr. Marshall B. West, class of 1901, of Catonsville.

Third—Dr. Henry Alan Naylor, class of 1900, of Pikesville.

Fifth—Dr. Cyril E. Fowble, class of 1910, of Arcadia, Md.

Sixth—Dr. Joseph S. Baldwin, class of 1874, of Freeland.

Seventh—Dr. Eugene W. Heyde, class of 1892, of Parkton.

Eighth—Dr. Benjamin Robert Benson, class of 1873, of Cockeysville.

Ninth—Dr. Richard C. Massenburg, class of 1884, of Towson.

Tenth—Dr. Josiah T. Payne, class of 1868, of Sunny Brook.

Twelfth—Dr. William E. McClanahan, class of 1902, of Baltimore.

Drs. Randolph Winslow, class of 1873; A. M. Shipley, class of 1902; E. H. Kloman, class of 1910; Nathan Winslow, class of 1901, and Frank

S. Lynn, class of 1907, have been elected honorary members of Chi Zeta Chi Fraternity.

Hyman R. Weiner, senior medical student, 1630 McCulloh street, has been elected resident physician at the Harrisburg Hospital, and received notification of his election April 29. The hospital has 104 beds.

We regret to note that Dr. Marshall B. West, class of 1901, of Catonsville, has pneumonia.

Miss Elizabeth C. Patterson, University Hospital Training School for Nurses, class of 1911, has resigned as assistant superintendent of nurses of the University Hospital.

We have been asked for the addresses of the following alumni of the University Hospital Training School for Nurses:

Miss Vera Wright, class of 1909, Presbyterian Hospital, New Orleans, La.

Miss Mary Barton Saulsbury, class of 1909, Guilford Apartments, Baltimore, Md.

Miss Emily Lavinia Ely, class of 1909, care of Miss Flanagan, Jacksonville, Fla.

Miss Lucy Briscoe Barber, class of 1910, 1403 Madison avenue, Baltimore, Md.

Miss Gertrude Anne Garrison, class of 1910, "Havendale," Burgess Store, Va.

Miss Mary Morgan Kimmel, class of 1910, 304 E. Lafayette avenue, Baltimore.

Miss Sarah Lillian Long, class of 1910, 21 N. Carey street, Baltimore.

Miss Lula Conway Price, class of 1910, 21 N. Carey street, Baltimore.

Miss Florence Dandlet King, class of 1910, Baltimore Eye and Ear Hospital, W. Franklin street, Baltimore.

Miss Sarah Ambrose Lee, class of 1910, 21 N. Carey street, Baltimore.

Miss Mary Constance Wiggin, class of 1910, U. S. Naval Hospital, Norfolk, Va.

Miss Marie Belle Murchison, class of 1910, 1403 Madison avenue, Baltimore, Md.

Miss Virginia Opie McKay, class of 1910, 21 N. Carey street, Baltimore, Md.

Miss Cora Nellie Burton, class of 1910, 640 W. North avenue, Baltimore, Md.

Miss Anne Melisse Drye, class of 1910, 21 N. Carey street, Baltimore, Md.

Miss Pauline Brook Pleasants, class of 1910, 311 E. North avenue, Baltimore, Md.

Miss Frances May Meredith, class of 1910, 1403 Madison avenue, Baltimore, Md.

Miss Margaret Means Taylor, class of 1910, 21 N. Carey street, Baltimore, Md.

Miss Adele Davis Barrett, class of 1910, 21 N. Carey street, Baltimore, Md.

Miss Ellen Coleman Israel, class of 1910, 1403 Madison avenue, Baltimore, Md.

Miss Agnes Kirk Holland, class of 1910, 21 N. Carey street, Baltimore, Md.

Miss Naomi Viola Hissey, class of 1907, 21 N. Carey street, Baltimore, Md.

Miss Mary Erie Grimes, class of 1907, 21 N. Carey street, Baltimore, Md.

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We are glad to report that Dr. Frank S. Lynn, class of 1907, who has been ill with pleurisy, has sufficiently recovered to be out again.

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Dr. Thomas A. Ashby, class of 1873, of 1125 Madison avenue, was a guest in Lexington, Va., during the past month. He was initiated into the Phi Beta Kappa Fraternity, to which he was recently elected, at his Alma Mater, Washington and Lee University. Phi Beta Kappa is said to be the oldest Greek letter society in the country, having been established at William and Mary in 1770. Election now is accorded only to men of eminence in their special line of activity. Dr. Ashby made the trip by automobile, accompanied by Mr. William C. Page, who was his companion on his trip to Europe last year.

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Dr. Howard V. Dutrow, class of 1904, formerly of Frederick, Md., who has been stationed in the hospital at Ancon, Canal Zone, was elected secretary and treasurer of the Medical Association of the Isthmus Canal Zone at the regular monthly meeting of the association held in the Ancon Hospital on Wednesday evening, March 13, 1912.

Dr. Dutrow's selection to the position is quite an honor. The association has a membership of over 100 and is affiliated with the American Medical Association. It is analogous to the Medical and Chirurgical Faculty of Maryland, and has the same designation as all State associations. Col.

W. C. Gorgas is one of the ex-presidents of the association.

For the past six years Dr. Dutrow has been employed in the medical service of the United States Government at Panama, and for some time past has been stationed at the Ancon Hospital, the second largest hospital in the world, in the capacity of assistant chief of clinic eye, ear, nose and throat department. The Ancon Hospital is the principal Government hospital on the Isthmus.

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Dr. Howard A. Kelly's "Cyclopedia of American Medical Biography" is deeply interesting to University of Maryland men. We regret that a sketch of Corbin Amos does not appear in this book, inasmuch as we have so long been accustomed to regard his diploma as an "outward visible" evidence of the veneration in which the beholder should keep our school. Dr. Cordell has named quite a few other distinguished Maryland physicians (Old Maryland, April, 1912) whom he deems more than worthy of a place in its pages, but, in spite of its omissions, Dr. Kelly's book will meet a much-needed requirement of the medical profession, and will continue in service as an authentic record for many generations. Among the University alumni and professors whose sketches appear in this book are:

#### Doctors—

Isaac Edmondson Atkinson, class of 1865, late dean of the medical school of the University, and father of Dr. A. Duvall Atkinson, class of 1894.

Ashton Alexander, provost from 1837 to 1850. Roberts Bartholomew, class of 1852.

Henry Willis Baxley, class of 1824, one of the founders of the first dental college in the world.

Alexander Hamilton Bayly, class of 1835.

George W. Boerstler, class of 1820.

Thomas Hepburn Buckler, class of 1835.

Elisha DeButts, professor of chemistry in the University from 1809 (then the College of Medicine in Maryland) until his death, in 1831.

James Cocke, one of the founders of the University, partner of Dr. John Beale Davidge.

William Alexander Clendenin, class of 1840, ophthalmologist.

Samuel Chew, class of 1829, professor of principles and practice of medicine, 1852-1863, father of Emeritus Professor Chew.

Julian J. Chisolm, professor of surgery in the

University, and father of Dr. Frances Miles Chisolm, class of 1889.

Joshua I. Cohen, class of 1823, probably the earliest aurist in America.

John Beale Davidge, founder of the University.

Francis Donaldson, class of 1846, first professor of physiology in the University of Maryland, and father of Dr. Donaldson, class of 1883.

*(To be continued.)*

## MARRIAGES

Dr. William Cuthbert Lyon, class of 1907, was married to Miss Bella Eleanor Flaccus, daughter of Mrs. William Flaccus of Ben Avon, Pa., on Friday, April 12, 1912, at Ben Avon. Dr. and Mrs. Lyon are spending their honeymoon in Europe. They will be at home in Baltimore after September 1, 1912.

Dr. Bennett F. Bussey, class of 1894, of Texas, Baltimore county, Maryland, was married on April 26, 1912, to Miss Katherine M. Craig, daughter of Mr. and Mrs. Robert Craig, also of Texas. The couple were married in Baltimore at the residence of Cardinal Gibbons by Rev. R. C. Campbell of St. Joseph's Catholic Church of Texas. The bride was attired in a traveling suit of steel gray, with black hat, and carried a bouquet of pink roses with a shower of lilies of the valley. The witnesses were Miss Mary Craig, sister of the bride, and Dr. Henry S. Jarrett of Towson. Dr. Bussey is a former president of the Baltimore County Medical Association and a member of the Medical and Chirurgical Faculty of Maryland.

## DEATHS

David Thomas Bowden, class of 1889, chief surgeon of the orthopedic department of the Patterson General Hospital, died at his home in Patterson, N. J., March 18, 1912, aged 46 years.

Dr. William H. Feddeman, class of 1888, of Roland Park, Md., died April 12, 1912, at the Northampton Court Hotel, Baltimore. Dr. Feddeman was a native of Virginia and came to Baltimore about 20 years ago. He graduated from the University with honors and served in the University Hospital for a time. He had a large practice, and of late years his health had begun to break because of overwork. He is survived by

his wife and a daughter, Miss Emma Feddeman.

Medical Director George E. H. Harmon, U. S. N., class of 1872, died at Cambridge, Md., March 5, 1912, aged 64 years. Dr. Harmon entered the service December 20, 1873, as an Assistant Surgeon, being retired because of age on March 5, 1910, in the grade of Medical Director, with rank of Captain.

Dr. Harmon was the dean of the Medical Corps of the Navy. His service afloat covered over 17 years. He has seen active duty in almost every part of the world, and always did credit to the corps and his country. He was in command of the Naval Hospital at Yokohama, Japan, from September 27, 1900, to December 24, 1902, and of the Naval Hospital at Washington, D. C., from July 30, 1908, to June 20, 1910. Dr. Harmon had a high sense of duty and marked executive ability. He gave many valuable contributions to literature on subjects of naval medicine. His kindly nature and marked general and professional ability made him many friends. Dr. Harmon was never married. He was an active member of the Association of Military Surgeons since 1902.

Col. Louis W. Crampton, Medical Corps, U. S. A., class of 1869, died at San Bernardino, Cal., April 12, 1912, from pneumonia, aged 63 years.

Dr. Crampton was born in Maryland May 8, 1848. He graduated from the University in 1869, and became an Assistant Surgeon in the Army on June 26, 1875. He was granted the following promotions: Captain, June 26, 1880; Major, September 6, 1895; Lieutenant-Colonel, August 9, 1903, and Colonel, April 23, 1908.

He served with troops at Fort Sheridan, Fort Spokane, Fort Meade, and in Washington, D. C., and St. Louis as medical supply officer. He served two terms of duty in the Philippines, the second as Chief Surgeon of the Philippine Division, and had returned to the United States, after being relieved of this duty, and was awaiting retirement at San Bernardino when he was stricken by death. Dr. Crampton was a member of the American Medical Association.

As we go to press we learn of the death on May 11, 1912, of Dr. Ephriam Hopkins, class of 1859, for many years a practitioner in Darlington, Harford county, Maryland. Dr. Hopkins was a brother of Dr. William Worthington Hopkins, class of 1858, who died last year.



# THE HOSPITAL BULLETIN

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No. 4

ADDRESS TO THE GRADUATES OF THE  
TRAINING SCHOOL FOR NURSES OF  
THE UNIVERSITY HOSPITAL, MAY  
15, 1912.

By RANDOLPH WINSLOW, A.M., M.D., LL.D.

*Young Ladies of the Graduating Class of 1912:*

Certain days in our lives stand forth separate from all other days, and are epochs in our history. One such day we are assembled to celebrate on this occasion, the Commencement Day of the class of 1912. For three long years of arduous effort you have looked forward to the time, when amid the plaudits of your friends, the fragrance of flowers and the discourse of delightful music, you should receive the coveted diplomas, testifying that you are qualified and equipped for the exercise of your professional calling. This time has now arrived, and it is my pleasant duty to extend to you the hearty congratulations of your officers and teachers, as well as my personal felicitations, upon the completion of the years of strenuous training and of work well done; and to bespeak for each of you a useful, honorable and successful career. While your term of pupilage ceases with the conclusion of these exercises, I wish to warn you that you must not imagine that your days of study are over; in fact they have but just begun. You must either go forward or fall to the rear, you cannot stand still. You have hitherto been lead and guided, but in the larger and freer life upon which you are now entering you will have to assume individual responsibility; and you must be prepared to meet these responsibilities as they arrive. You will need, therefore, to continue to study not only text-books and journals, but the various conditions of disease with which you come into contact, as well as the individual patients themselves. Study persistently, observe carefully, and keep accurate

notes of your cases. Strive not only to excel in your professional work, but to add to your store of knowledge, and of general culture. You have chosen a life of service, and you will have to sacrifice ease and pleasure to a large extent. You will be brought in contact with all kinds of people, some of them kind and considerate, some rude and churlish. To each class you must be patient and gentle, soft of speech, unruffled in temper, and of unfailing cheerfulness. You must remember that those who are brought low by sickness and suffering are not altogether responsible for their actions and words, and that they may do and say that which they would not do or say under other circumstances. You will only too often be called upon to minister to those who are passing through the valley of the shadow of death, and it may be your duty and privilege not only to alleviate their physical pain and distress, but at times to speak words of hope and cheer to those who are without hope or light. This responsibility may not be avoided or lightly put aside, and a ministering angel is she who not only soothes the anguish of those who are about to pass over the river, but shows the way of salvation to those who are perishing. Cherish high ideals, have a broad charity, and emulate the examples of those noble women who have only recently been summoned to "come up higher"—Florence Nightingale and Clara Barton.

Florence Nightingale may well be called the founder of modern training schools for nurses. Previous to her time nurses were usually well meaning but ignorant women, without education and devoid of the most elementary knowledge of caring for the sick; often some old crone, loquacious and egotistical, who was ready to do the wrong thing whenever the opportunity offered. Frequently the nurse was a loving member of the family, a devoted mother or wife, who sacrificed herself unselfishly, but who did not

possess the necessary qualifications. Florence Nightingale was born of English parents at Florence, Italy, in 1820, and died at London in 1910, aged more than 90 years. She attended a training school for deaconesses in Germany in 1849, and subsequently continued her studies in the hospitals of London and Paris. Upon the outbreak of the Crimean War the cry came from the field, "Are there no devoted women among us able and willing to go forth and minister to the sick and suffering soldiers at the hospitals of Sentari?" Miss Nightingale responded and selected 38 female nurses, and went to the front. They found conditions most deplorable, the hospitals filthy and infected with vermin, and cholera and pestilence raging. Order was soon brought out of chaos, new conditions were brought about, and death yielded to recovery in ever increasing proportions. From her custom of visiting her patients at midnight she became known as the Lady with the Lamp, and has been immortalized in the lines:

"A lady with a lamp shall stand  
In the great history of the land,  
A noble type of good,  
Heroic womanhood."

She accompanied the troops into the field, and was often under fire, and rendered such heroic service that she became a national heroine, and was the recipient of the highest honors. A popular subscription of \$250,000 was raised and presented to her, which she refused to accept, and asked that it be used to found the Nightingale Home and School for Nurses at St. Thomas' Hospital, London. Notwithstanding the impairment of her health from her work during the Crimean War she lived to a very ripe old age, known and honored the world over.

Clara Barton was born at Oxford, Mass., in 1821, and died at Glen Echo, Md., in 1912, aged 91 years. She was a school teacher at Bordentown, N. J., but on account of poor health removed to the city of Washington shortly before the Civil War, and obtained a clerkship in the Patent Office. Upon the outbreak of the war she volunteered for service in caring for the sick and wounded, and like Florence Nightingale devoted herself to her self-imposed task with such assiduity and success that her fame spread far and wide. When war broke out in 1870 between Germany and France she again responded to the

call of humanity and rendered invaluable services to the sick and wounded. Upon her return to the United States she succeeded in gaining governmental recognition of the Red Cross Convention, and was chosen the first president of the American Red Cross, which position she retained until her death. These women had a broad vision of their duty to humanity and they did not shrink from the performance of this duty even at the sacrifice of comfort, health and life, if need be. I hope that we may be spared the horrors of war and of the pestilence that walketh in darkness, but if these calamities should befall us I am sure that you will not fail to do your duty, as those of whom I have just spoken did theirs. One may be as much of a hero, however, in the performance of the every-day duties of life as in the sudden and thrilling episodes of a spectacular character. I believe that a life spent in the service of our fellowmen will not fail of recognition by the Almighty, and that the ultimate sacrifice, the laying down of one's life that others may live, will not fail of its reward. In the recent appalling disaster upon the sea some met their fate with words of praise and of prayer upon their lips; others looked death in the eye without quailing, and met their doom doing their best to save the weak and helpless. May God in his boundless love have mercy upon them all. Folger McKinsey, the Bantztown bard, pays a beautiful tribute to these heroic souls who died that others might live.

"I'm glad, Jack Astor, you died that way!

Goodby, Jack Astor, Goodby!

I am glad you showed us what men become

When they look death straight in the eye.

You'd been a bad fellow, I guess, in a style

That you didn't yourself think bad;

But you died like a thoroughbred gentleman—

Goodby, Jack Astor, I'm glad!"

"They say he was bad, and I guess he was,

But I think God will forget;

There's a bit of the bad in the best of men.

And there's going to be lots of it yet:

But it washes out in the end, my friend,

When we try Jack Astor's plan,

Who saved the women and saved the kids,

And turned and died like a man."

"Astor, and Archibald Butt, and Case—

Goodby, brave spirits, goodby!

Why, even the men that live by mistakes

Are gentlemen when they die.

Soldiers and heroes and all that men

In their manly measure should be,

When they look dead straight in the eye of fate

On the land or on the sea!"

The best preparation for a heroic death is to live a godly life, and I do not wish to seem to condone a careless life, even when it culminates in the greatest sacrifice that one can make. "Greater love hath no man than this, that a man lay down his life for his friends." It may be that in the supreme moment of self abnegation God will forgive and forget our past misdeeds. John Hay expresses the same sentiment in his poem, Jim Bludsoe.

"He weren't no saint—but at judgment

I'd run my chance with Jim,

'Longside of some pious gentlemen

That wouldn't shook hands with him,

He seen his duty, a dead sure thing—

And he went for it thar and then ;

And Christ ain't a-going to be too hard

On a man that died for men."

We live in a momentous age, in fact, in the most wonderful period of the world's history; time and space are being annihilated, and the visions of the prophets and the dreams of the poets are being fulfilled. In 1513 Vasco Nunez de Balboa, from the crest of a hill on the Isthmus of Panama, first saw the vast ocean lying at his feet, which on account of its tranquility he called pacific, and Pacific Ocean it has remained to this day. Soon the thought was entertained of connecting the Atlantic and Pacific Oceans by means of an artificial waterway, and now the dream of the centuries is an almost accomplished fact. The voyage of Columbus in 1492 was for the purpose of discovering a more direct route from Europe to the Indies, and he went to his grave with his hopes unrealized. In our day the fulfillment of his dream is at hand. The construction of the Panama Canal is the most stupendous engineering undertaking that the world has ever seen, and with its completion, a little more than a year hence, the greatest triumph of mind over matter will have occurred. This triumph will have been accomplished by means of American brains and American money. What

has enabled our countrymen to successfully accomplish this colossal task, which the French undertook and gave up in despair? The French had the necessary engineering ability, and they expended vast treasure in the undertaking, but they were not able to compete with the pestilential diseases of the Isthmus, and their employes died like flies. It is on account of the better sanitation inaugurated by the Americans that the canal has been built. The Isthmus of Panama, like Cuba, Porto Rico and the Philippine Islands, has become a location in which men can live and work in as much safety and in almost as much comfort, as in the temperate zones. For this change from a tropical inferno to a tropical paradise the University of Maryland is to a large extent responsible, and by this change the construction of the canal has been made possible. In 1891 James Carroll, an enlisted man in the United States Army, graduated from the Medical School of this University, and in 1899 he was appointed a member of the yellow fever commission, whose duty it was to investigate the cause and prevention of yellow fever. He voluntarily subjected his hand to the bite of a stegomia mosquito that had bitten a yellow fever patient, and promptly contracted the disease, and in his own person proved his faith that yellow fever is conveyed from person to person by means of this variety of mosquito, and by no other means. By destroying the breeding places of the mosquitoes, and by screening the habitations of persons living in the tropics, yellow fever has been practically wiped out, as has malaria also. All honor to Carroll, and to Lazear, and to Reed, the other American members of the yellow fever commission, all of whom have passed from works to rewards.

Not only in Panama, but in various parts of our own country, we see stupendous undertakings inaugurated and, in a few years, carried to a successful completion; so that the physical characteristics of the land are in many places being entirely transformed. The great miasmatic swamp area of Florida, known as the Everglades, is being drained, and a vast tract of ooze and slime, where alligators and reptiles, with furtive Indians, hold sway, will soon be added to the productive lands of the country. In passing I may say that this reclamation is being accomplished by Mr. Frank Furst, a citizen and resident of this city. On the other hand, the vast

arid areas of our Western domain are being rendered fertile and productive beyond comprehension by the impounding of the mountain streams into artificial lakes, and the irrigation of the waterless lands. As one travels through New Mexico, Arizona, Nevada and other far Western States, he crosses vast tracts of dry alkaline plains, where the dust is stifling and the heat like that of a fiery furnace; where no foliage is to be seen except, perhaps, gray sage bushes and thorny cacti, and where the ground is cracked and parched and uttering its prayer for rain. If by chance some one with a vision hears the cry and brings water to these thirsty deserts, they blossom as the rose and bring forth some thirty, some sixty and some many hundred fold.

The vivid flash of the lightning as it extended across the heavens, associated with the deafening crash of thunder, has brought terror to many from time immemorial. It seemed to the affrighted spectator that the wrath of God was about to be visited upon the earth, and that sinful men were to be overwhelmed by the righteous indignation of the Almighty. Benjamin Franklin saw a vision, and from his experiments in 1746 with his kite we have the electricity harnessed and made to serve the useful purposes of man. In 1844 Samuel F. B. Morse, already an artist of note, succeeded in interesting the Government in a device of his invention, and the first telegraphic message in the world, "What hath God wrought," was sent over the wires from Washington to Baltimore. The submarine cable now connects the nations of the world with each other as with friendly hand clasps beneath the sea; and the telephone enables us to hear the voice of loved ones who may be many hundred miles away. A few years ago the Italian, Marconi, succeeded in sending messages through the air and over the seas, without wires, and this invention is of the most far-reaching importance. The recent tragedy of the sea, the wreck of the leviathan Titanic, was robbed of some of its horror by the heroic devotion to duty of its wireless operator, Phillips, who continued to send out the cry for help, until the great ship plunged beneath the waves, and he met his fate in the icy waters. The call was heard, however, and more than 700 lives were saved.

Who has not admired the wonderful flight of the eagle or the soaring of the vulture, and how many persons have dreamed of flying through

the air? Those mythological personages, Daedalus and Icarus are represented to have attempted flight from Crete to Sicily with wings made of feathers and wax. The youthful Icarus flew too high, and the heat of the sun melted the wax and he fell into the sea and was drowned, but the more prudent Daedalus kept at a lower level and reached his destination in safety. Since that time men have not trusted themselves to wings of feathers and wax, but the dream of flight through the air has been entertained from time to time as an object not beyond successful accomplishment. Through the genius of Count Zeppelin the dirigible airship has become a reality, and regular passenger service is maintained between certain cities in Germany. It is, however, still a hazardous and uncertain voyage, and one can embark more safely, though more slowly, in an ox-cart. A few years ago Orville and Wilbur Wright saw a vision, and the heavier than air aeroplane was evolved, and though far from perfect at present, C. P. Rogers was able to cross from the Atlantic to the Pacific Coast at a speed of more than a mile a minute. These are some of the wonderful results that have been accomplished in our day, by those who have seen visions and have followed the light. Many others equally as startling might be mentioned, did time and opportunity permit. Truly the impossible is being made possible, and in our time is the prophecy being fulfilled, that "it shall come to pass in the last days, saith God, I will pour out of My spirit upon all flesh \* \* \* and your young men shall see visions, and your old men shall dream dreams." I have preached you a very drowsy and prosaic sermon, and I must not tax your forbearance farther.

Let duty be the guiding spirit of your lives. Be faithful in little things, and if a great and overwhelming crisis should overtake you, you will be faithful even unto death. Be loyal to yourselves, to your school, to your patrons and to your calling. Have a broad vision; look up and not down. Observe the signs of the times, and go forward. Be hopeful and helpful. A life of service to others is the ideal life. Success is relative and depends upon the point of view. The most successful life is the one of the greatest usefulness.

In this broad sense I again wish you useful, honorable and successful careers.

# SOME FACTS DEALING WITH THE DEVELOPMENT OF ASEPTIC SURGERY.\*

By R. A. ALLGOOP, '12.

The first record of surgery we have is 400 years B. C., or the time of Hippocrates, who is generally known as the Father of Medicine, but I think he has a just right to be called the Father of Surgery, for he discoursed wisely and elaborately of fractures, of joints, of the structures and diseases of the bones, of ulcers, of fistulas and hemorrhoids. In addition to this, his writing deals with trephining, with reduction of hernia, with herniotomy and lithotomy by both the perineal and suprapubic route.

He described pneumothorax and opened and drained the chest for empyema.

This was a good start on the road to success of surgery, but the traveling was slow until the century that is immediately behind us, which brings with it memories we are not likely to forget.

Twelve years ago we began the present century by celebrating the achievements of the last century, and the more we inspect those 100 years of progress, the more remarkable they appear.

In 1894 Billings wrote: "More progress in the art of surgery has been made since 1800 than had been made in the 2000 years preceding that date." And I think that all men of today will agree that Joseph Lister has been the leading factor in the progress.

He was born on April 6, 1827, at Upton, in Essex county, England. He is not a Scotchman, as many think, though his notable work was done in Scotch universities.

Joseph Lister followed his father's trade as a wine merchant in London for a while after his father's death, but in spite of the claims of business he felt the claims of science more strongly.

One cannot say just when it was that Lister began constantly turning his mind to the problem of a remedy for wound infection—perhaps he himself could not tell us—but he must have been dwelling upon such things very early in his career.

We may conceive of the conditions in those old hospitals and in wounds in general from the de-

scription in the books and from the tales of men whose professional memories go back 35 years or more.

In the hospital surgical sepsis ran until secondary hemorrhage, erysipelas, septicemia, pyemia and hospital gangrene were endemic; sometimes wards, wings or whole institutes were closed in vain attempts to stamp out these disorders. Operations in private houses, especially in the country, were less dangerous than in hospitals, but in private-house operations the mortality was high.

Sometimes a surgeon would wear the same old operating coat for years, and would pick waxed ligatures from the button-hole of his assistants, who carried them there for the convenience of his chief. Old hands will tell you such stories by the score, but to the modern surgeon such practices are uncondonable. The explanation the men of the early part of the eighteenth century gave of septic fevers was that all septic fevers are due to sympathetic action of the nervous system, as when a part is injured nature contends for a cure by stopping the function of all the uninjured organs, and thus turning aside their blood supply to the injured part, setting up inflammation and so attempting a cure.

Lister remained in Edinburgh in the early part of his life until 1860, his thirty-fourth year, and it was during the last of this period that he began his bacteriological studies in connection with aseptic surgery. With an eye single to this great problem, he kept a lookout for what the rest of the world was doing, and it was at this time that the significant researches of Pasteur attracted him. Louis Pasteur was five years Lister's senior. The son of an old Peninsula war veteran, he was well educated for a scientific career, and by 1860 he had convinced himself of the importance of the rôle played by microbes in the production of fermentation as opposed to the old views of Liebig that it is a change in organic fluids and tissues set in motion by the excess of oxygen of bodies in a state of decomposition. After the demonstration of the cause of fermentation, there followed experiments and discussions on spontaneous generation and the establishment of Pasteur thesis of the non-existence of such generation.

Lister's growing belief in an external agent as the cause of wound infection was strengthened and confirmed by Pasteur's researches, for in 1867 he was able to write. Turning now to the ques-

\*Read before Randolph Winslow Surgical Society, March 22, 1912.

tion how the atmosphere produces decomposition of organic substances, we find that a flood of light has been thrown upon this most important subject by the researches of Pasteur.

He believed at this time—and for many years afterwards—that the air was the vehicle which brought poison to wounds, though he recognized then—and with increasing perception as the years passed—that all foreign substances, as clothing, skin, instruments, sponges, ligatures, were also contagion carriers. Even before finding a satisfactory antiseptic, he insisted that operators and dressers should be scrupulously clean, and he employed many deodorant lotions about the wounds.

He had then decided that putrefaction and supuration were distinct processes, and were due to distinct causes. He regarded wound infection as putrefaction, and what wonder, considering that putrefaction did frequently occur and simulate inflammation of the most virulent type!

The science of bacteriology was in its infancy, and no one appreciated the different forms of organisms, much less the distinction between pathogenic, pyogenic and saprophytic bacteria.

At this time Lister's ingenuity was exercised especially in some cases of compound fractures in which the mortality had always been great, and it was in such cases in 1864 that he proposed to use his new remedy. He recognized that the most severely lacerated simple fractures healed without special disturbance, and, convinced as he was that it was the air admitted to compound fractures which rendered them dangerous, he sought to reduce them to the simple state by excluding air or by opposing to the air a barrier which should render harmless its offending germs. So he wiped out the wound with pure carbolic acid and then sealed it with lint soaked in carbolic acid. The exudation mingling with the acid formed a paste which soon hardened into a scab. In order to prevent too rapid evaporation of the agent, he laid over this dressing a block-tin shield. So long as active inflammation did not appear, the carbolic scab was painted daily with more carbolic, to keep in a fresh supply of the germicide, and the shield was reapplied daily. The surprising success of this treatment in the cases of compound fractures led to its employment in abscesses and fresh wounds.

Sometimes it was impossible to secure exudate of proper quality to mix with the carbolic for a paste, so an artificial paste of linseed oil, carbonate

of lime and carbolic acid was tried. This was Lister's famous antiseptic putty.

Until 1877 antiseptics came and went; the carbolic spray was used and was banished. Air was found not to be a dreaded enemy and carrier of disease, but a kindly friend when properly used.

Surgical cleanliness, a germ-free environment, became recognized as the one thing needed.

So today we have aseptic surgery in the place of septic surgery, because heat, soap and water, the nailbrush, alcohol and a few simple chemicals have replaced the use of non-sterile instruments, sutures and dirty hands, all of which go to make the past century one of progress in relation to surgery.

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The following postal was received from Dr. Michael Hanna, class of 1910, of Tanta, Egypt:

*"Dear Dr. Nathan Winslow:*

*"Yesterday I sent you by mail \$5. Please forward one of them to Dr. Cordell for Old Maryland, and the rest are what George and myself owe to the BULLETIN.*

*"If I can get spare time, I will collect from between my papers the scattered notes I have on two operations I performed lately and send them to you. One of them is a Caesarian section on a woman 25 years old for a contracted pelvis. Am sure you will be surprised to hear me calling it a bloodless operation. Only a few small sponges were used from the beginning to the end. The other operation is peculiar for its rarity. It was a large abscess of the spleen complicating malaria. I had to perform a laparotomy for it. The abscess contained about two pints of pus; the whole spleen looked like a bag of pus floating freely in the abdomen. Result is splendid in both operations.*

*"Best regards to you, Professors Winslow, Coale, Mitchell, Shipley and all."*

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Dr. Joseph Collins, class of 1909, of Calvert, Cecil county, Md., was seriously injured in a runaway June 3. His buggy was overturned and he lay for several hours before someone found him and carried him to a nearby house. His head is badly cut, and his knee sprained, and it will be weeks before he will be able to resume his practice.

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Dr. John Willis Abbitt, class of 1910, has been appointed a coroner in Portsmouth, Va.

## BREAST AFFECTIONS—A SERIES OF 100 CASES.

By RANDOLPH WINSLOW, M.D., LL.D.,  
Professor of Surgery, University of Maryland,  
and

NATHAN WINSLOW, A.B., M.D.,  
Associate Professor of Surgery in the University  
of Maryland.

From a series of 100 cases of affections of the breast occurring in the University Hospital during the past few years, we have been able to elicit the following facts: Sixty-three were carcinomas, 3 sarcomas, 20 fibro-adenomas, 3 adeno-cystomas, 1 adeno-fibro-cystoma, 1 systic fibroma, 2 galatocoeles, 3 tubercular mastitis, 1 pericanilicular fibro-myxoma, abscess 3.

All but one were women, or 99 per cent.; the male had a fibro-adenoma; 69 of the patients were married, 27 single; the social status of 4 was not recorded; 88 were of the white race, 12 of the colored; 76 did housework, the occupation of 10 was not stated; one was a farmer, 2 saleswomen, 1 a stenographer, 1 a cook, 1 a factory hand, 3 laundresses, 1 a dressmaker, 2 were teachers, 1 a clerk, 1 a music teacher.

The right breast was affected in 40 instances, the left in 58; in the remaining instances the affected organ was not mentioned; 94 of the individuals were subjected to operation, with 92 operative recoveries and 2 deaths.\* Two refused operation, and in 4 the involvement was too extensive for an operation.

The tumor came under the observation of the surgeon within the first week of its discovery by the patient in five instances; within one month in 5; within two months in 6; within three months in 9; four months 3; five months 1; six months 7; nine months 4; one year 6; two years 16; three years 5; four years 2; five years 1; six years 2; seven years 2; fourteen years 1; eighteen years 1; twenty-eight years 1; not stated 13.

Taking the series as a whole, the largest number of cases came under the observation of the surgeon during the third decade of life, there having been 25 between 30 and 40 years of age, while the fourth decade presented a nearly equal proportion, with 23 cases; 48 per cent. of all the cases

came to the hospital for treatment during the period between 30 and 50 years of age.

*Carcinoma:* The cases of carcinoma were 63 in number. The period of greatest frequency was in the fourth decade, when 19 cases occurred, which corresponds with previous statistics. Of this series only 3 occurred before the thirty-fifth year, 56 at a later period, 3 not being recorded; 10 occurred before the fortieth year, 49 afterwards. The youngest age recorded was 17 years. In this case a supposedly fibro-adenoma was removed, but a microscopical examination, made by Prof. Hirsh, showed the tumor to be undergoing beginning adeno-carcinomatous changes. The next youngest in our series was 26 years of age. Fifty-seven of the 59 cases with age recorded occurred after the thirtieth year of age. The oldest patient was 82 years old; she was operated on and made a good operative recovery. Of the 12 colored patients in the general list, 7 were affected with carcinoma, or 58.3 per cent. The youngest of these was 37 years of age. These figures seem to indicate that in the colored race cancer is not only relatively less frequent, but is also actually less prevalent than in the white, for of the 88 white patients, 55 were the subjects of carcinoma, 62.5 per cent., as compared with 58.3 per cent. for negroes. A family history of cancer was obtained in 16 instances, and of trauma in 14. The growth had ulcerated in 10, and was attached to the skin or muscles in 26. The axillary glands were palpable in 32. The growth was located in the upper and outer quadrant in 15, lower and outer in 6, upper and inner in 9, lower and inner in 1. The size varied from that of a marble to a clenched fist, and even larger in several instances. The growths were removed by Halsted's radical method in 37 instances, and by Meyer's method once; the breast and axillary glands without removal of the pectoral muscles in 19. In 3 involvement was too extensive for successful removal, and 2 refused operation.

The importance of subjecting every growth to a thorough microscopical examination was demonstrated by the following case: The operator, thinking he was dealing with a fibro-adenoma, enucleated the growth, but subsequently he was informed the growth was carcinomatous, and the patient returned for a breast amputation. In another instance, after having removed a doubtful growth, the operator was advised that a frozen section indicated carcinoma. He therefore im-

\*Deaths. One followed a palliative operation and occurred quite suddenly; cause unknown. The other probably resulted from pneumonia.



mediately performed a radical operation, and later was informed that the growth, on further microscopical examination, was innocent. Thus even frozen sections are not invariably reliable, but under such circumstances as mentioned above it is the best policy to remove the breast at the time of the original operation and not delay, even though, as in this case, the operative procedures were more mutilating than was necessary.

The diagnosis appended to the charts in the cancer series was simple carcinoma, 37; sirrhous carcinoma, 20; medullary carcinoma, 1; adeno-carcinoma, 5. In eight instances there was a history of post-operative recurrence, but as no post-operative history was obtained of most of the cases, a definite statement cannot be made as regards the actual number of recurrences.

A history of more or less pain was obtained from 42 of these patients.

In the cancer series a growth was known to have been in existence for the following periods: One week, in 9 cases; two weeks, in 1; three weeks, 1; two months, 2; three months, 8; four months, 4; six months, 5; nine months, 3; one year, 10; two years, 10; three years, 4; four years 1; five years, 1; seven years, 2; fourteen years, 1; twenty-eight years, 1.

Glancing at the length of existence of the tumor in the cancer series, forcibly reminds us that as soon as a lump is discovered in the breast it should be removed. In one case the growth was in existence for 5 years, two for 7 years, one for 14 years, one for 28 years, and quite a number from one to two years. Surely, if all of these had been extirpated in their incipiency, at least some of the cancer victims would have escaped.

*Sarcoma:* There were three cases of sarcoma. The time of life at which they occurred was as follows: 34 years, 51 years and 52 years. Although this series is very small, the ages are rather remarkable. Sarcoma, as a rule, occurs before the fortieth year. Here we have two after the fiftieth. One of these cases was a myxo-sarcoma. There was pain in two.

*Adeno-Fibroma:* There were 20 cases of adeno-fibroma, distributed as follows: The oldest patient with adeno-fibroma was 45. The greatest number of cases occurred between the ages of 30 and 40, during which decade nine cases came under observation. To our mind, there is no doubt that some of these tumors would have eventually undergone malignant degeneration if

they had not been extirpated. There was pain in six of these cases.

*Fibro-Myroma:* There was one case of fibromyxoma, occurring in a colored girl aged 17 years.

*Cystic-Fibroma:* One case of cystic-fibroma was observed, occurring in a white woman 27 years of age. There was pain in this case.

*Tubercular Mastitis:* There were three cases of tuberculosis of the breast, occurring at the following ages: 40, 44 and 60. Of these three cases two were mistaken for malignant disease and one was correctly diagnosed clinically. The diagnosis in the other cases was made by means of microscopical examination. There was some pain in all these cases. The last case two years subsequently returned to hospital complaining of severe pains in right breast. On examination no lump was palpable; the breast soft and apparently not affected; it was, however, amputated, with no relief of pain.

*Galatocoele:* Two cases of galatocoele were observed, occurring at the following ages: one at 25 years and one at 35 years. There was pain in one of these cases.

*Adeno-cystoma:* There were three cases of adeno-cystoma, aged, respectively, 16, 21 and 47 years. There was pain complained of in two of these cases.

*Adeno-fibro-cystoma:* One case of adeno-fibro-cystoma was observed, aged 51 years.

Ether was used as an anesthetic in practically all cases, but in one serious case the induction of insensibility to pain by the use of HMC tablets was thoroughly tested. At 9 A. M. hyocine gr. 1/200, cactine gr. 1/134, morphine gr. 1/8 was administered hypodermically, and the same dose was repeated at 10.30 A. M. When brought to the operating table at 10.45 A. M. the patient was asleep, but could be awakened sufficiently to understand what was said to her, and would protrude her tongue if told to do so, but would not speak in answer to questions, and would lapse immediately into slumber. The plantar reflex was present; the pupils were dilated; the respirations were deep and the pulse was full (120 per minute), but regular and of good tension and volume. The breast and axillary glands were removed without great inconvenience to the patient. When returned to bed she continued to sleep profoundly not awakening until 5 P. M., when she regained consciousness without nausea or other bad effect.



The skin was moist and the glandular activity was apparently not affected. Her condition for several days following operation was satisfactory, then she grew progressively worse until death.

The importance of subjecting the extirpated growth to a microscopical examination was illustrated by a case which was diagnosed carcinoma and on pathological examination proved to be fibro-adenoma; another, diagnosed clinically fibro-adenoma, was found to be undergoing malignancy; still another, diagnosed carcinoma, on microscopical examination showed tuberculosis of the breast; another was diagnosed sarcoma, and was later found to be scirrhus carcinoma; another, diagnosed carcinoma, was, in fact, tuberculosis of the breast; still another was diagnosed carcinoma of the breast, and was really a fibro-adenoma, and finally one diagnosed fibroma was found to be adeno-carcinoma.

The 12 cases occurring in colored persons were as follows:

Carcinoma 7, aged 37, 39, 43, 47, 58, 62 and 56 years, respectively.

Sarcoma 1, aged 51 years.

Galatocoele 1, aged 25 years.

Adeno-cystoma 1, aged 16 years.

Fibro-myxoma 1, aged 17 years.

Tuberculosis of breast 1, aged 62 years.

The writers are aware that they have not made any specially valuable contribution to medical knowledge by the tabulation of these cases. The number is too small, the records too meager and the pathological investigations too superficial to enable us to do more than show the general characteristics of an unselected series of 100 cases. Of several facts, however, they are convinced from their own observation, as well as from the recent literature on the subject of mammary tumors. One of these facts is that it is impossible to know whether a given growth is innocent or malignant until a proper microscopical examination has been made. If possible, a frozen section should be made by a competent person and reported on immediately, in order that the surgeon may be guided as to the necessity of performing a radical or a partial operation. When, however, there is a well-grounded doubt as to whether the tumor is benign or otherwise, the patient should be given the benefit of the doubt, and the radical operation should be performed. Secondly, no girl or woman is justified in keeping a growth in her breast, and this injunction is the more imper-

ative as the woman advances in age. All breast tumors should be removed in their incipiency; benign tumors may become malignant, and malignant tumors in a short time may become diffused and beyond successful and permanent eradication. Thirdly, carcinoma probably is somewhat less frequent in proportion to other neoplasms than is generally taught; 63 per cent. of our cases were carcinomata, but this is probably too low a percentage for a normal ratio, and sarcoma occurs in only a small percentage of cases (3 per cent. in this series), which is probably more frequent than is normal.

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#### REMARKS AT THE ANNUAL REUNION OF THE MEDICAL ALUMNI ASSO- CIATION, JUNE 1, 1912.

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By MICHAEL VINCIGUERRA, 1912.

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*Professors, Doctors and Fellow-Students:*

It is easy to imagine in what state of perplexity I find myself when you consider that I am facing at present not only my classmates, but my illustrious teachers, whom for many years I have been accustomed to listen to with great interest and profit.

To be present at this gathering is a great honor, and to stand before this audience I consider it a great privilege. I am sure that on such an occasion as this there is ample room for an orator to be at his best in order to meet the great task before him, but since I have not the gift of speech-making, and since I have to deal with a "foreign tool of expression," I trust you will pardon me should I say less than what I feel.

First and foremost it is my fervent desire to extend my thanks to those who for many years, and day after day, have tried to infuse within us the best that medical science offers—I mean you, my most esteemed teachers. It is my wish to impart to you—you, the delineators of our future careers—you, the guides of our tortuous and rough path—you, the stimulators and sources of anything that is of any good within us, it is to you, I have said, that I, as well as the class of 1912, eagerly desire to extend our sincere gratitude for the constant effort you have made during the past years to inculcate in our minds and heart the best of your vast knowledge and long experience. Nor does our sentiment of appreciation toward you end with the expiration of

these feeble words of recognition (I have said words of recognition), for really I have no such utterances as to meet this task. I am destitute of any expression of thanks for what we owe you, and for this reason I am compelled to bury in silence most of our debt of duty that by right should be accorded you.

At present the only thing that we have stored at the bottom of our hearts is our knowledge of being ever your debtors. In this acknowledgment there is the signature of each and every student of the class of 1912 who, while not promising you that we shall be successful physicians, do promise and assure that we shall endeavor our utmost to become at least desirable citizens.

Our actions shall be ever directed so as to give you no opportunity of regretting the time, effort and energy that you have consumed upon us.

Next in order I would like to thank you, my kind classmates—ever desirable companions—faithful and sincere friends in necessity—I wish I were able to appropriately express to you my warmest sentiment of appreciation for the numerous courtesies you have constantly shown me. Ever since the first time that I have had the fortune of meeting you I have seen in your eyes ever an inviting glance; in your face always an encouraging, smile, accompanied with friendly words. In case of necessity I have found you constant and faithful—in case of action, ready to act.

But this is not all. You have even gone a little farther. You have unanimously elected me a member of the "House Committee" and secretary of your class. Also secretary of the Randolph Winslow Surgical Society—positions that ought to have been occupied by a better person and a more qualified student than myself. Of course all these pleasant and not to be forgotten, unforgetful events, all converge toward one direction.

They conspicuously set forth reflections of your kindness toward strangers—a reflection of your hospitality toward foreigners—a reflection of sacrifice and egotism for altruism—qualities that can be found only in a civilized nation and among those students that are free from selfishness.

Gentlemen, I owe you more than I can do you justice in words. The time that I have spent with you shall be a sweet remembrance of my future days.

I admit that I do like America very much, but I must confess that I like you more. In the past I have been very happy to be and to study with you; at present I rejoice to eat, drink and chat with all of you, and in the future I would be only too glad if I could spend the rest of my days in your company.

Teachers, classmates and friends, let me thank you at least once more, and since this is the last time that we shall all meet together allow me to do this by shaking your hands.

June 1, 1912.

The Medical Alumni Association held its annual meeting at the Hotel Caswell on Saturday, June 1, 1912, at 8 P. M.—The President, Dr. Charles E. Sadtler, class of 1873, presided. The toastmaster was Dr. G. Lane Taneyhill, class of 1865. The orator of the evening, Rev. Lynn Harold Hough, D. B., pastor of Mount Vernon Place Methodist Church, used as his subject, "The Measure of a Man." Professor Arthur M. Shipley, class of 1902, made a short address. Solos were rendered by Mr. Hobart Smock and Dr. B. Merrill Hopkinson, class of 1885. Dr. Robert Abell, president of the class, responded to the toast to the class of 1912.

The menu was as follows:

Little Neck Clams	
Olives	Radishes
Gumbo a la Caswell	
Bay Shad, Maitre de Hotel	Saratoga Chips
Crab Flake en Cases	
Filet of Beef	
Mushrooms	Green Peas
Lettuce with Tomato Salad	
Neapolitan Ices	
Cafe Noir	Cigars

The new officers for 1912-13 are: President, Dr. C. R. Winterson, class of 1871; vice-presidents, Drs. W. E. Wiegand, class of 1876; H. L. Naylor, class of 1900; W. S. Maxwell, class of 1873; recording secretary, Dr. Nathan Winslow, class of 1901; assistant recording secretary, Dr. J. C. Macgill, class of 1891; corresponding secretary, Dr. John I. Pennington, class of 1869; treasurer, Dr. John J. Houff, class of 1900. Executive committee: Drs. G. Lane Taneyhill, class of 1865; B. M. Hopkinson, class of 1885; Geo. A. Fleming, class of 1884; V. L. Norwood, class of 1885; H. C. Houck, class of 1905.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JUNE 15, 1912.

## THE AMERICAN MEDICAL ASSOCIATION AND THE MEDICAL COLLEGES.

Since 1904, the Council on Medical Education has done a great, though somewhat arbitrary work, in the collection and compilation of facts concerning medical education in this country; the publication of State Board statistics; and the investigation and rating of medical schools.

In 1904, there were 166 medical colleges in the United States. In the eight years that have elapsed since then, 46 schools have gone out of existence, and 120 are still in operation. There has been a great advance in medical education, even in the weak schools. An inspection of the schools has been recently completed, and they have been rated in accordance with this investigation. While injustice may have been done to some, there can be no doubt as to the general accuracy of the ratings. There are still too many medical colleges, and it is the avowed purpose of the American Medical Association to compel the merging or extinction of schools until there shall not be more than 70 left. These must be thoroughly equipped for the proper instruction of students in medicine. It will be a matter of the survival of the fittest. The Council is exerting pressure to compel the merging of the University of Maryland, College of Physicians and Surgeons, and Baltimore Medical College, into one institution, and the closing of other weaker schools. An effort is now being made to accomplish this

merger, and to make one strong and high-class medical school. Something must be done: the unaffiliated, unendowed medical school is an anachronism, that cannot much longer exist. The Faculty of Physic is determined that every personal sacrifice shall be made to comply with the demands of the times, and that we shall have a first-class school or none.

In the meanwhile don't forget the pathological endowment fund, which is sadly needing contributions.

### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1868.....	10 00
1871.....	35 00
1872.....	70 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	35 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	15 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	25 00
1900.....	215 00
1901.....	185 00
1902.....	305 00
1903.....	300 00
1904.....	145 00
1905.....	200 00
1906.....	155 00
1907.....	110 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to June 1, 1912..\$9056 50

## NEW SUBSCRIPTIONS IN MAY.

Dr. W. Ward Olive, 1906.....	\$25 00
Dr. Marshall B. West, 1901.....	10 00
Frank P. Marsden, Esq.....	10 00
E. A. & B. M. Watts.....	10 00
J. J. Landragan, Esq.....	5 00
Cash.....	1 00

Additions for the month..... \$61 00

# THE ONE HUNDRED AND FIFTH ANNUAL COMMENCEMENT.

The annual commencement of the University of Maryland was held at the Lyric, Saturday afternoon, June 1, 1912, at 4 o'clock. The order of exercises was as follows:

- Overture—"Raymond".....A. Thomas  
 Selection—"Quaker Girl".....Caryl  
 Waltz—"Enchantress".....Victor Herbert  
 1. Music—March, "Tannhauser".....R. Wagner  
 2. Prayer by Rev. Thomas Grier Koontz.  
 3. Music—Song, "Rosary".....E. Nevin  
 4. Address to the Graduates, Edgar H. Gans, LL.D.  
 5. Music—"U. S. Patrol".....Thomas  
 6. Conferring of Degrees by the Provost of the University.  
 Candidates for the Degrees "Bachelor of Arts" and "Bachelor of Sciences" presented by the Dean of the Faculty of Arts and Sciences.  
 Candidates for the Degree "Doctor of Medicine" presented by the Dean of the Faculty of Physic.  
 Candidates for the Degree "Bachelor of Laws" presented by the Dean of the Faculty of Law.  
 Candidates for the Degree "Doctor of Dental Surgery" presented by the Dean of the Faculty of Dentistry.  
 Candidates for the Degree "Doctor of Pharmacy" presented by the Dean of the Faculty of Pharmacy.  
 7. Conferring of Honorary Degrees.  
 8. Music—"Chanson Sans Paroles".....Tchaikowsky  
 9. Award of Prizes.  
 10. Music—March, "Lorraine".....Ganne  
 L. H. Fisher, Director of Orchestra.

There were 228 graduates. They were presented by the deans of their respective departments, and were classified as follows:

Bachelor of Arts.....	16
Bachelor of Science.....	3
Doctor of Medicine.....	75
Bachelor of Laws.....	50
Doctor of Dental Surgery.....	59
Doctor of Pharmacy.....	25

## Students who received degrees are:

## BACHELOR OF ARTS.

Edgar Stanley Bowhus.  
 John Arthur Brashears.  
 Clarence Leewood Dickinson.  
 Charles Griffith Haslup.  
 Herman Richard Holljes.  
 Robert Spencer Hopkins.  
 Spencer Drummond Hopkins.  
 Wilhelm Lentz.  
 Benjamin Michaelson.  
 Frederick Appel Miller.  
 Louis Earnest Payne.  
 Charles Holland Riffin.  
 Raymond Staley.  
 Arthur Everett Williams.  
 George Leiper Winslow.  
 Samuel Rowland White, Jr.

## BACHELOR OF SCIENCE.

Philip Langdon Alger.  
 William John Jones.  
 Kenneth Edgar Wilson.

## DOCTOR OF MEDICINE.

Robert Ephraim Abell, South Carolina.  
 Reese Alexander Allgood, South Carolina.  
 Robert Glenn Allison, South Carolina.  
 Angel Virgilio Aviles, Ecuador, S. A.  
 George Cullen Battle, North Carolina.  
 Grover Cleveland Beard, North Carolina.  
 Bernard Mark Bergarttt, Maryland.  
 Harry Aloysius Bishop, District of Columbia.  
 Robert Alexander Bommer, Maryland.  
 Sidney Eli Buchanan, North Carolina.  
 William Thomas Chipman, Delaware.  
 Charles Peter Clautice, Maryland.  
 Wilfred Rivers Claytor, South Carolina.  
 James Daniel Cochran, North Carolina.  
 Thomas Joseph Connors, Connecticut.  
 John Dade Darby, Maryland.  
 Russell Hardy Dean, Jr., Florida.  
 Harry Deibel, Maryland.  
 John Bernard Donovan, Maine.  
 James Archie Duggan, Georgia.  
 John William Ebert, Virginia.  
 Ernest William Frey, Maryland.  
 William Edwin Gallion, Jr., Maryland.  
 Dawson O. George, Maryland.  
 Abraham Goldstein, New York.  
 William Granville Haines, Maryland.  
 Judson E. Hair, South Carolina.  
 Edward H. J. Hennessey, Connecticut.  
 Milford Hinnant, North Carolina.  
 James Edward Hubbard, Maryland.  
 Henderson Irwin, North Carolina.  
 Edward Sooy Johnson, Maryland.  
 John Kent Johnston, Florida.  
 Charles Loring Joslin, Maryland.  
 M. Randolph Kahn, Maryland.  
 Edwin Paul Kolb, Maryland.  
 Daniel Henry Lawler, Connecticut.

Simon Geilech Lenzner, New York.  
 Moses Louis Lichtenberg, Maryland.  
 Bertrand Allen Lillich, Pennsylvania.  
 Everett Alexander Livingston, North Carolina.  
 Enrique Llamas, Colombia, S. A.  
 Edward Anderson Looper, Georgia.  
 Benjamin J. McGoogan, North Carolina.  
 Andres Martin G. de Peralta, Cuba.  
 William Michel, Maryland.  
 Benjamin Newhouse, Maryland.  
 John Charles Norton, Maryland.  
 Roger Vinton Parlett, Maryland.  
 Robert Bruce Patrick, South Carolina.  
 Philip Pearlstein, Texas.  
 Charles Wm. Rauschenbach, Maryland.  
 Harry Herman Rich, New Jersey.  
 Joseph Rottenberg, Maryland.  
 Wilbur Moate Scott, Georgia.  
 Jay D. Sharp, Indiana.  
 Everett Alanson Sherrell, North Carolina.  
 David Silberman, Maryland.  
 John Andrew Skladowsky, Maryland.  
 Clarke Jackson Stallworth, Alabama.  
 John Clinton Stansbury, Maryland.  
 Grover A. Stem, Maryland.  
 Thomas F. A. Stevens, Maryland.  
 Jesse Cunningham Stille, Pennsylvania.  
 Edward Charles Straessley, Pennsylvania.  
 William C. Terry, North Carolina.  
 John Henry Trahand, Jr., Maryland.  
 Gerardo Vega y Thomas, Cuba.  
 Michael Vinciguerra, New Jersey.  
 Harold Homer Webb, Virginia.  
 Edwin V. Whitaker, Louisiana.  
 Hyman R. Wiener, Pennsylvania.  
 Robert Cleveland Williams, North Carolina.  
 W. Howard Yeager, Pennsylvania.  
 Henry Zimmerman, Massachusetts.

## PRIZEMAN.

University prize, gold medal, Charles William Rauschenbach.

*Certificates of Honor.*

Edwin Paul Kolb,	William Granville Haines,
Robert Ephraim Abell,	Robert Alexander Bommer,
	William Michel.

## BACHELOR OF LAWS.

Benjamin Baker,	Horace Edgar Flack,
Joseph Albert Baker,	William Earl Fraley,
Charles William Bald,	Harry Walter Ganster,
Lewin Wethered Barroll,	Lawrence Wolf Goldheim,
Robert Dixon Bartlett,	John Biddison Gontrum,
Levin Creston Beauchamp,	Homer Ewing Holt,
Hyman Nathaniel Blaustein,	Edward Everett Johnston,
Albert Page Boyce,	Josiah Purnell Johnson,
Karl Edw. Meikle Bubert,	William Leigh, Jr.,
Raymond Herman Bubert,	Lewis Rudolph Lemke,
Francis James Carey,	Harry Oscar Levin,
Malcolm Joseph Coan,	William Penn Lewis, Jr.,
Henry Doeller, Jr.,	George Wash. Lindsay,
Allan Herbert Fisher,	James Russell Manning,

Nathaniel Thos. Meginnis,	Ernest Ruediger,
Louis Mitnick,	Charles George Schrt,
Carl Gage Mullin,	Everard Pattison Smith,
Albert Graham Ober, Jr.,	Thos. Alexander Smith, Jr.,
William Allen Owings,	Clarence Edward Steer,
Frank Robert Paterson,	John Samuel Turner, Jr.,
Philip Benjamin Perlman,	George Ross Veazey,
Samuel Benjamin Plotkin,	Samuel Woodson Venable,
Virtume P. Alphonse Quinn,	Edward Philip Waldschmidt,
Alfred Nicholas Reichert,	George Schubert Weikart,
Richard Hynson Rogers,	David Angle Wolfinger.

## DOCTOR OF DENTAL SURGERY.

Leslie Talmage Allen, Canada.  
 William Lury Baugher, Virginia.  
 Don Allen Bernhardt, West Virginia.  
 Harry William Binder, Maryland.  
 John Aloysius Black, New Jersey.  
 Paul Hewitt Blanchard, Vermont.  
 David F. Blatt, Maryland.  
 William Henry Bond, Georgia.  
 Harold Ellsworth Bonney, Virginia.  
 Aubrey Hopper Burk, New Jersey.  
 John Osborne Camp, Connecticut.  
 Walter Herbert Clark, New Hampshire.  
 Roy Ben Dawson, West Virginia.  
 Luke William Delaney, New Jersey.  
 Robert Henry Ellington, North Carolina.  
 Francis John Ellison, Maryland.  
 Henry Edward Fitzpatrick, New Hampshire.  
 Dawson Young Flook, Maryland.  
 Arthur Clay Foard, Maryland.  
 Isaac I. Ganzburg, Connecticut.  
 Herbert Thomas Grempler, Maryland.  
 Joseph John Hamlin, North Carolina.  
 J. Francis Healey, New York.  
 Frank Trump Herr, Maryland.  
 Robert Lee Hicks, South Carolina.  
 Thomas Halliday Hoffman, Pennsylvania.  
 David Thomas Borthwick Houston, New Jersey.  
 Hamilton Jefferson, Georgia.  
 John Frederick Marshall Keighley, Rhode Island.  
 Frederick Leo Kenna, New Jersey.  
 Walter Scott Kennedy, New York.  
 George Earle Kirschner, Pennsylvania.  
 William Llewellyn Lloyd, Maryland.  
 John Alexander McClung, Virginia.  
 Joseph Maurice Mansir, Maine.  
 Alfred Eugene Martin, New Jersey.  
 Curtis Whitney Merrill, Rhode Island.  
 Frederick Olmsted Moore, Vermont.  
 Miguel Montesinos, Porto Rico.  
 Henry Forman Ortel, Maryland.  
 Lawrence Randolph Outten, Delaware.  
 George Kernodle Patterson, North Carolina.  
 Berkeley Miller Pemberton, Virginia.  
 Ralph Ray, North Carolina.  
 John L. Remsen, New Jersey.  
 Paul Salles, Louisiana.  
 Carl Edward Schlieder, New York.  
 Elton Ashby Sims, Maryland.

Albert James Sinay, Connecticut.  
 Meyer Everett Sinsky, Maryland.  
 Wylie Isaac Smith, New Jersey.  
 Minot Benton Stannard, New Jersey.  
 Joseph B. Steinberg, Maryland.  
 Henry Streich, Maryland.  
 James J. Sullivan, New Hampshire.  
 Herbert Ambrose Thrift, Rhode Island.  
 Norman Charles Thurlow, Maine.  
 Carlos A. Walker, Maryland.  
 Owings C. Woods, South Carolina.

## PRIZEMAN.

University prize, gold medal, Leslie Talmage Allen.

*Honorable Mention.*

Thomas Halliday Hoffman.

## DOCTOR OF PHARMACY.

Hugh Kelly Borland, Maine.  
 Sidney Joseph Brown, Florida.  
 Benjamin Bruce Brumbaugh, Maryland.  
 Clarence A. Davis, South Carolina.  
 Hermann Dietel, Jr., Texas.  
 Ethan Oglivie Frierson, South Carolina.  
 Harry Sherman Harrison, Maryland.  
 Henry Felix Hein, Texas.  
 Lee Hodges, South Carolina.  
 Dennis Paul Lillich, Pennsylvania.  
 George Lucius McCarty, Virginia.  
 John Gordon McIndoe, Maryland.  
 Charles Edwin McCormick, Maryland.  
 Frederick Minder, Maryland.  
 Carrie G. Mossop, Maryland.  
 Robert Reginald Pierce, Maryland.  
 Lloyd Nicholas Richardson, Maryland.  
 Joaquina Ruiz de Porras, Porto Rico.  
 Thomas Stanley Smith, Virginia.  
 John Alfred Strevig, Pennsylvania.  
 Harold A. Swartz, Maryland.  
 Randall Cholmondeley Ward, West Virginia.  
 Daniel Andrew Warren, Maryland.  
 James J. Wolfe, Maryland.  
 John Stanley Yakel, Maryland.

## PRIZEMAN.

Gold medal for general excellence, Hermann Dietel, Jr.

*Certificates of Honor in Order of Merit.*

Lee Hodges,  
 Henry Felix Hein,  
 Sidney Joseph Brown.

## SPECIAL PRIZES.

Simon medal for superior work in chemistry, Hermann Dietel, Jr.

*Junior Class—Honorable Mention in Order of Merit.*

B. Olive Cole,  
 James W. Watkins,  
 Thomas A. Crowell.

## ABSTRACT

## TECHNIC OF RESECTION OF RIB UNDER LOCAL ANESTHESIA.

At the recent meeting of the Medical and Chirurgical Faculty of Maryland Dr. Charles Bagley, Jr., class of 1904, in a paper on the technic of resection of rib under local anesthesia, had the following to say (*Journal A. M. A.*, May 18, 1912):

*Dr. Charles Bagley, Jr., Baltimore.*—"General anesthesia does not seem to be altogether safe. The lung, which has perhaps been the seat of pneumonia, is now mechanically compressed by the accumulation of pus in the pleural cavity. In addition, air is allowed to enter the cavity during operation as the pus escapes, possibly causing serious difficulty. Local anesthesia, if it can be successfully produced, seems to be the proper method of protecting these patients against the severe pain of the operation. The patient is placed on the side opposite the disease. The field of the operation is prepared either in the usual manner or by the iodine method. The eighth rib is selected and the area infiltrated with Schleich's solution, beginning just to the inner side of the apex of the scapula and then extending three inches outward in the direction of the rib, care being taken to inject this solution into the true skin. An incision is then made from within a half inch of the outer extremity. The fibers of the latissimus dorsi muscle are now exposed and infiltrated with the solution, then divided. On retraction the periosteum will be exposed and may be anesthetized by vigorously rubbing in powdered cocaine on an applicator, or injecting Schleich's solution under the surface, both methods seeming to act well. An incision is then made in the periosteum in the direction of the rib, an inch and a half long, and midway between the upper and lower border. From either end of the incision a cross-incision is made, extending from the upper to the lower border of the rib entirely through the periosteum. A periosteal flap is then formed above and below and is dissected from the outer surface of the rib. A pledget of cotton in a small mosquito forceps is dipped into the powdered cocaine and the exposed surface of the rib vigorously rubbed until it is insensible to pain. Care must be taken that the wound is dry in order that blood and serum

may not cause the cocain to flow along the lower portion of the wound and be absorbed. When the rib is partially cocainized the separation of the periosteum is again undertaken with a periosteum elevator. After final cocainization, the bone is divided by Liston's forceps, only the point of the blade being used, the instrument being held in a vertical position. When about one inch of the bone is removed a glistening surface is seen underneath. This is injected with Schleich's solution and an incision as large as desired made in the direction of the rib. Drainage-tubes are inserted and a couple of tucks of gauze placed at the angle of the wound, all secured by a safety-pin. Sutures are omitted—to save time and because of the importance of securing primary union in the presence of infection."

### ITEMS

Dr. Raymond Garrison Hussey, class of 1911, who has been resident physician at the tuberculosis hospital at Bayview, has resigned to accept a like position at the State Sanatorium, Sabillasville, Md.

Dr. Norman Thomas Kirk, class of 1910, has passed the Army examinations and will receive his commission in the United States Medical Reserve Corps (active) as First Lieutenant July 1, 1912.

Miss Florence V. King, class of 1910, University Hospital Training School for Nurses, has charge of St. Luke's Hospital, Fayetteville, N. C.

Miss Mattie Estelle Coale, class of 1912, University Hospital Training School for Nurses, will engage in district nursing here in Baltimore.

The following appointments at the University Hospital for the coming year have been announced:

Assistant resident surgeons: Dr. FitzRandolph Winslow, class of 1906; Drs. Robert E. Abell, William E. Gallion, Edward E. Looper and Henderson Irwin, all of the class of 1912. Assistant resident physicians: Drs. Charles W. Rauschenbach, Reese A. Allgood, William M. Scott and Judson E. Hair, class of 1912. Residents at the maternity hospital: Drs. Louis Hariman Douglass, class of 1911. John D. Darby and William Michell, class of 1912. Assistant resi-

dent gynecologists: Drs. William L. Byerly and Louis Kyle Walker, both of the class of 1911. Resident pathologist: Dr. Moses L. Lichtenberg, class of 1912, and alternate, Dr. Robert A. Bonner, class of 1912.

The following alumni have died during the year:

Robert Atkinson, class '54, died at Baltimore May 22, aged 79.

Norman F. Hill, class '82, died at Baltimore May 13, aged 61.

Jno. R. T. Reeves, class '58, died at Chaptin, Md., April 14, aged 79.

Richard Sappington, class '51, died at Baltimore, Md., May 14, aged 84.

Stephen H. Griffith, class '90, died at Gaffney, S. C., May 13, aged 44.

Thos. H. Beltz, class '63, died at York, Pa., May 11, aged 69.

Edwin G. Darling, class '82, died at Laura-ville, Md., June 6, aged 52.

G. E. Milton Smith, class '88, died at Baltimore, Md., May 22, aged 43.

Van E. De Lashmott, class '54, died at Shelburn, Ind., May 25, aged 79.

Robt. H. Gantt, class '09, died at Fort Sam Houston, Tex., June 10, aged 27.

Wm. Worthington Hopkins, class '58, died at Havre de Grace, Md., August 4, aged 74.

Geo. W. Truitt, class '75, died at Baltimore, Md., July 11, age 65.

Joel W. Nixon, class '78, died at St. Louis, Mo., August 25, aged 62.

Luther M. Zimmerman, class '64, died at Woodsboro, Md., September 13, aged 71.

Jos. Penn Chaney, class '52, died at Breatheds-ville, Md., October 3, aged 81.

Lawrence Sterling Alexander, class '68, died at St. Augustine, Fla., November 6, aged 68.

Jno. Reese Uhler, class '61, died at Baltimore, Md., October 9, aged 72.

Napoleon B. Nevitt, class '57, died at Accotink, Va., September 25, aged 81.

Oliver J. Gray, class '02, died at Wilmington, Del., September 29, aged 31.

Geo. Edward Gilpin, class '82, died at Berkeley Springs, W. Va., November 3, aged 65.

Harry V. Harbaugh, class '07, died at Cambridge, Md., November 10, aged 28.

Andrew C. Dukes, class '71, died at Columbia, S. C., November 30, aged 61.

Wm. E. Gaver, class '88, died at Mt. Airy, Md., December 31, aged 48.

Pierre G. Dausch, class '68, died at Baltimore, Md., November 26, aged 65.

Summerfield Berry Bond, class '83, died at Baltimore, Md., December 21, aged 50.

Wm. F. Hengst, class '76, died at Baltimore, Md., December 4, aged 57.

Benj. F. Price, class '57, died at Mt. Carmel, Md., December 15, aged 76.

Jos. V. Milton, class '01, died at Lacy Springs, Va., December 16, aged 35.

Wm. C. P. Boone, class '72, died at Baltimore, Md., December 30, aged 67.

Enoch George, class '72, died at Denton, Md., January 12, aged 61.

Louis W. Morris, class '85, died at Salisbury, Md., February 2, aged 46.

Gilbert C. Greenway, class '68, died at Hot Springs, Ark., January 19, aged 71.

Norton R. Hotchkiss, class '91, died at New Haven, Conn., January 30, aged 41.

Mathias A. E. Borek, class '63, died at St. Louis, Mo., January 20, aged 77.

Harry B. Gantt, class '80, died at Baltimore, Md., January 20, aged 54.

John L. Blair, class '68, died at Mercersburg, Pa., December 31, aged 66.

Jos. L. Muncey, class '91, died at Penhook, Va., December 29, aged 45.

Nathan D. Tobey, class '63, died at Vaughn, N. M., January 19, aged 74.

Peter H. Lathan, class '76, died at Wetherly, Pa., January 23, aged 62.

Julius Levin, class '05, died at Johnstown, Pa., February 12, aged 32.

Geo. E. H. Harmon, class '72, died at Cambridge, Md., March 5, aged 64.

Thos. Robert Dougher, class '09, died at Avoca, Pa., February 16, aged 27.

Daniel Thos. Bowden, class '89, died at Patterson, N. J., March 18, aged 46.

William T. Arnold, class '75, died at Baltimore, Md., March 31, aged 67.

Jno. Evans Mackall, class '08, died at Elkton, Md., April 4, aged 29.

Floyd W. Rogers, class '02, died at Newport, R. I., March 26, aged 52.

Wm. H. Feddeman, class '88, died at Baltimore, Md., April 12, aged 46.

Louis W. Crampton, class '69, died at San Bernardino, Cal., April 12, aged 63.

Wm. A. Henchman, class '73, died at McKeesport, Pa., April 19, aged 63.

John W. Fields, class '60, died at Chincoteague Island, Va., May 4, aged 75.

Ephraim Hopkins, class '59, died at Darlington, Md., May 11, aged 75.

J. R. Bromwell, class '71, died at Washington, D. C., May 25, aged 70.

H. E. Bowman, class '39, died at Farmington, Iowa, April 29, aged 93.

*(Continued From May Number.)*

Among the University alumni and professors whose sketches appear in Dr. Kelly's *Cyclopedia of American Medical Biography* are:

John Fonerden, class of 1823, whose friendship with Johns Hopkins probably furnished the motive for the founding of the Johns Hopkins Hospital.

Charles Frick, class of 1845, and professor of *materia medica* and therapeutics in the University, in whose honor the Frick Library of the Medical and Chirurgical Faculty of Maryland is founded.

Aaron Friedenwald, class of 1860, president of the Medical and Chirurgical Faculty of Maryland, 1889.

Eli Geddings, professor of anatomy and physiology in the University from 1851 to 1857.

John D. Godman, class of 1818, the anatomist.

Horace H. Hayden, who received the honorary degree of M.D. at the University in 1840, founder of the Baltimore College of Dental Surgery.

William Travis Howard, professor of physiology in the University of Maryland, 1866; professor of diseases of women and children, 1867, and becoming emeritus professor 1897, University, LL.D., 1907.

Horatio Gates Jameson, class of 1813, one of the founders of the Washington Medical College and later president Ohio Medical College, editor *Maryland Medical Recorder*, and who preceded Lord Lister in antiseptic surgical work.

Christopher Johnston, class of 1844, founder Maryland Medical Institute, professor anatomy and physiology in the University from 1864 to 1869, and professor of surgery from 1869 to 1881, died 1891. One of Maryland's greatest surgeons.

Thomas Sargent Latimer, class of 1861, surgeon in the Confederate Army, editor *Baltimore Medical Journal*, and for many years president of the College of Physicians and Surgeons.



George Warner Miltenberger, class of 1840, dean of the University faculty, and professor of obstetrics, professor of therapeutics and materia medica, professor emeritus and honorary president of the Faculty, after spending over half a century in the service of the University.

Robert Brown Morrison, class of 1874, clinical professor of dermatology in the University, and pioneer dermatologist of Maryland.

Russell Murdock, lecturer on diseases of the eye and ear in the University, 1868-69.

James Croxall Palmer, class of 1834, later surgeon-general United States Navy, served in Mexican and Civil Wars, died 1883.

John Williamson Palmer, class of 1846, first city surgeon of San Francisco, a writer of note and one of the editors of the *Century* and *Standard* dictionaries.

Granville Sharp Pattison, appointed to the chair of anatomy, physiology and surgery in the University of Maryland in 1820, and who enjoyed a high reputation as an anatomical teacher.

Nathaniel Potter, first professor of principles and practice of medicine in the University, and holding this position until his death in 1843.

William Power, class of 1835, lecturer in 1841 at University Hospital, giving two remarkable lectures on exploration of the chest, successor of Elisha Bartlett, a great clinical teacher.

Joseph Roby, professor anatomy and physiology in the University, 1842.

George Henry Rohé, class of 1873, organizer of Springfield Hospital.

Irving Collins Rosse, class of 1866, army surgeon.

Moisés John DeRossett, adjunct to the professor of chemistry in the University and professor of chemistry in the Dental School.

Nathan Ryno Smith, professor of surgery in the University, 1827.

David Stewart, class of 1844, lecturer in the University on pharmacy, first independent professor of pharmacy in the United States.

Charles Alexander Warfield, president of the University in 1812-13.

John Doane Wells, professor of anatomy and surgery in the University from 1829 to his death in August, 1830.

Thomas Henry Williams, class of 1849, assistant surgeon in the United States Army, and afterwards surgeon in the Confederate Army.

Henry Parke Custis Wilson, class of 1851, practically the founder of gynecology in Maryland, died 1897.

Caleb Winslow, father of Drs. Randolph and John R. Winslow, and grandfather of Drs. Nathan and FitzRandolph Winslow.

William Maxwell Wood, class of 1829, native of Harford County, Md., army surgeon during Seminole, Mexican, Chinese and Civil wars, surgeon on Minnesota at time of battle between Monitor and Merrimac.

William Zollickhoffer, class of 1818, botanist.

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Among the medical men who attended the smoker of the General Alumni Association on May 31 at the Hall of the Medical and Chirurgical Faculty were Drs. Charles E. Sadtler, Randolph Winslow, Nathan Winslow, Eugene F. Cordell, J. M. Hundley, C. F. Nolen, B. M. Hopkinson, T. A. Ashby, C. R. Winterson, J. W. Holland, I. H. Davis, L. B. Henkel, Jr., John C. Hemmeter, H. M. Robinson, and the following members of the graduating class: George E. Bennett, Bernard M. Bergartt, Grover C. Beard, George Cullen Battle, Charles P. Clautice, W. Thomas Chipman, Thomas Joseph Connors, John Bernard Donovan, John Dade Darby, Harry Deibel, James Archie Duggan, John W. Ebert, Ernest William Frey, William Granville Haines, Edward Sooy Johnson, Everett A. Livingston, Bertrand Alley Lillich, Gerard Henry Lebet, Benjamin J. McGoogan, Andres G. Martin, Philip Pearlstein, Joseph Rottenberg, Grover A. Stem, John A. Skladowsky, John C. Stansbury, W. C. Terry, John Henry Traband, Jr., Michael Vinciguerra, Harold Hamer Webb, R. C. Williams. The attendance at the banquet was as follows:

Alumni, guests, newspaper representatives, 46; medical graduates, 29; dental graduates, 14; pharmacy graduates, 21; academic graduates, 12; unclassified, 18.

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Drs. Thomas Gay Whims, class of 1911, of Lasker, N. C.; Samuel J. King, class of 1903, formerly of Grand Junction, Col., but now located at Zanesville, Ohio; William V. Parramore, class of 1910, of the Georgia State Sanatorium; Morris Ramsey Bowie, class of 1908, of Somerset, Col.; Guy Philip Asper, class of 1903, of Chambers-

burg, Pa.; Charles R. Richardson, class of 1903, of Belair, Md., and John Nelson Neill Osburn, class of 1909, of Martinsburg, W. Va., were among the recent visitors to the University Hospital.

At the one hundredth commencement of the University and the one hundred and fifth of the medical school, honorary degrees were conferred as follows: Rev. Thomas Grier Koontz, Doctor of Divinity, presented by Mr. Philemon H. Tuck; Edgar Hilliary Gans, Doctor of Laws, presented by Judge Henry D. Harlan, and Robert Dorsey Coale, Doctor of Medicine, presented by Dr. Randolph Winslow. Professor Winslow, in recommending Dr. Coale for the degree, made the following remarks:

"Mr. Provost—I have the honor to present for the degree of Doctor of Medicine, *honoris causa*, one whom the Regents have adjudged worthy of this distinction and whose name is mentioned in their mandate. Robert Dorsey Coale, for 28 years professor of chemistry and toxicology in the University of Maryland, and for the past 12 years dean of the Medical Faculty of the same institution. Born and raised in Baltimore, Professor Coale received his early education in the private schools of this city, but having a predilection for military life, he entered the Pennsylvania Military Academy at Chester, Pa., from which he graduated in 1875. Upon the opening of the Johns Hopkins University in 1876 he became a student in the department of chemistry, and he has the distinction of having been the first matriculate of this famous institution, from which he received the degree of Doctor of Philosophy in 1881. In 1883 he was made lecturer, and in 1884 professor of chemistry and toxicology in the University of Maryland, of which chair he is still the incumbent. In addition to his activities as teacher and chemist, he has been especially identified with the Maryland National Guard, and upon the outbreak of the Spanish-American War was commissioned Colonel of the Fifth Maryland Regiment, U. S. V., Infantry, and served in the field with this regiment during the hostilities. In consideration of his scientific attainments and the valuable services rendered the Medical School during many years, I request that he be admitted to the degree of Doctor of Medicine in this University, *honoris causa*.

The financial report for The Alumni Athletic Association of the University of Maryland, Inc., for the past year is as follows:

#### RECEIPTS.

Membership dues.....	\$314 50
Sale of theater tickets.....	267 00
Donation from Law School.....	50 00
Donation from Dental Department.....	44 00
From raffle of instruments.....	89 80
Guarantees, etc., received from track team.....	14 00
Guarantees, etc., received from lacrosse team...	16 60
Guarantees, etc., received from baseball team...	133 00
Guarantees, etc., received from basket-ball team	326 27
Total receipts.....	\$1255 17

#### DISBURSEMENTS.

Theater Benefit—	
Paid Academy of Music.....	\$158 75
Printing, etc. ....	12 65
Postage on tickets.....	15 26
Refund over-payment.....	2 00
	188 56
Track Team—	
Suits, pole and shot.....	\$43 65
Printing .....	5 00
Expenses to meet.....	74 52
Medals for meet.....	41 00
	164 17
Basket-ball Team—	
Equipment .....	\$101 00
Printing, postage, etc.....	9 00
Expenses to games.....	308 81
	418 81
Lacrosse Team—	
Stationery .....	\$3 00
Postage .....	1 00
Expenses to Annapolis.....	15 00
Equipment .....	28 80
	47 80
Baseball Team—	
Expenses to games.....	\$255 00
Equipment—part payment.....	25 00
	280 00
Association Expenses—	
Stationery and supplies.....	\$40 20
Postage (stamped envelopes).....	20 80
Clerical work.....	2 00
Costs incorporation.....	8 00
Membership A. A. U.....	7 50
	78 50
Miscellaneous—	
Two footballs.....	\$10 00
Use M. A. C. grounds.....	5 00
Walbrook Athletic Club.....	25 00
Instruments for raffle.....	28 00
	68 00
	\$1245 94
Balance May 30, 1912.....	\$9 23

## ENGAGEMENTS

The engagement is announced of Dr. Howard J. Maldeis, class of 1903, of 437 East 25th street, Baltimore, to Miss Louise Cecil Watkins, daughter of Mr. and Mrs. W. M. Watkins of Kate avenue, Arlington, Md. The wedding will take place in the early fall. Miss Watkins was a member of the class of 1913, University Hospital Training School for Nurses.

## MARRIAGES

Dr. William Shepherd Hall, class of 1899, of 814 Park avenue, Baltimore, was married to Mrs. Katherine Turner Kurtz of Roland Park, in Philadelphia, June 1, 1912. The wedding was witnessed by the young son of the bride, her cousin and brother-in-law.

## BIRTHS

In March, 1912, to Dr. Granville Hampton Richards, class of 1908, and Mrs. Richards, of Port Deposit, Md., a daughter. Mrs. Richards was Miss Mary Emma Wright, class of 1908, University Hospital Training School for Nurses.

February 3, 1912, to Dr. Jacob Wheeler Bird, class of 1907, and Mrs. Bird, a daughter, Helen Brayshaw Bird. Mrs. Bird was Miss Mary McIntire Wilson, of Centerville, and former assistant superintendent of nurses in the University Hospital.

## DEATHS

Dr. Josiah R. Bromwell, class of 1871, of Washington, D. C., died at his home, 1147 Connecticut avenue, May 25, 1912, after a lingering illness. He was a native of Frederick County, and after graduation located in Loudoun County, Va., where he remained for ten years, spending the past thirty in Washington. He is survived by his brother, Dr. John Bromwell, class of 1867, of Mount Airy, Md. Dr. Bromwell was buried in London Park Cemetery, Baltimore.

Dr. Ephriam Hopkins, class of 1859, died at his home in Darlington, Harford County, Md., Saturday, May 11, 1912, aged 75 years. Dr. Hopkins was the son of the late Dr. Wakeman B. Hopkins, class of 1828, and Mrs. Hannah R. Hopkins, and cousin of the late Dr. William Worthington Hopkins, class of 1858, who died August 4, 1911. Dr. Ephriam Hopkins was born

in 1837 near Darlington, Md., and received his earlier education in the schools of that vicinity, later matriculating at the University, from which he was graduated with honors in 1858. For a time he practiced in Darlington, then located about four miles from West Chester, Pa., where he had entire medical charge of the large Chester County Almshouse, with a department for the insane, and here did the work of two physicians, as this almshouse was at that time also the hospital of the county. About 1895 Dr. Hopkins returned to Darlington and purchased the beautiful Joseph Jewett residence, where he resided until his death. He married Miss Rachael M. Johnson, a lady of rare talents, who survives him. Two sisters and a brother are still living. Dr. Hopkins' two sons died some years ago, just as they were about grown. He was a loyal member of the Society of Friends, and counted his warmest friends among its members.

Dr. Hopkins was an alumnus of whom the University may always be proud. Never robust, yet possessed of indomitable energy, he successfully conducted a practice that many men half his years could not have attempted. His practice was widespread and his neighborly spirit kindly enough to make no distance too great if he could alleviate suffering by his presence. He was a keen diagnostician, a tactful physician, a splendid and kindly nurse, and a friend to all of his patients and neighbors. He was one of the few physicians who possessed business ability in combination with professional skill.

His death was undoubtedly due to his devotion to his duty, as his last illness was contracted through taking a patient to a hospital. His physicians agreed that he literally laid down his life for another, following the call of duty as he saw it. His life was markedly free of excess of any kind, and he was always so active he seemed a very part of the community in which he lived.

Dr. Nathan R. Smith, late professor of surgery in the University, wrote of Dr. Hopkins to a colleague as follows:

"It gives me great pleasure to bear testimony to the superior intelligence and industry with which he has distinguished himself in the pursuit of his studies, taking the very front rank of his class. He has witnessed much of my private practice, aided me in many operations, and himself operated skillfully under my observation, and I, without reserve, commend him to all with

whom my name has influence as one in every respect worthy of entire confidence."

Dr. Hopkins was buried in Darlington Cemetery. Messrs. Charles Y. Thomas and Thomas Wheeler of the Society of Friends officiated. The pallbearers were Messrs. Johns Hopkins, Thomas C. Hopkins, James Massey, William Dick, William Scott and Norman Smith.

#### OLDEST ALUMNUS DIES.

We have just learned of the death of Dr. Humphrey E. Bowman, class of 1839, on April 29, 1912, at the home of his daughter in Farmington, Iowa. Dr. Bowman was the oldest living alumnus of the University for several years preceding his death, and we regret that we did not know this and accord him earlier the recognition this fact merited. We believe the honor now goes to Dr. John W. C. O'Neill, class of 1844, of Gettysburg, who was born in 1821, with a close second in Dr. John J. R. Krozer, class of 1848, of Baltimore, who was born in 1827.

Dr. Bowman was born in Loudoun County, Va., August 17, 1818, and grew to young manhood there. He received his higher education at the College at Marietta, Ohio, later matriculating at the University and graduating in 1839. He located at Shelbyville, Mo., and practiced there and in Newark, Mo., for over thirteen years. He returned to Baltimore two years after his graduation to marry Miss Ann M. Ellery. After leaving Newark he engaged in mercantile pursuits at various places, relinquishing medicine because of failing health. In 1861 he went to Iowa, locating at Farmington, where he has since made his home, with the exception of a short time spent in Missouri immediately following the Civil War and a brief period spent later in Chicago. He lived for many years with the daughter at whose home he died—Mrs. James W. Lapsley. He is survived by five children, W. H. Bowman of Keokuk, Iowa; C. A. and C. H. Bowman of Mt. Sterling; Mrs. James Lapsley of Farmington, and Mrs. E. E. French of Chicago, Ill.; and seven grandchildren and two great grandchildren. At the time of his death he was almost ninety-four years of age, and one of the oldest citizens of Van Buren County, and probably one of the oldest graduate physicians of Iowa.

Added to his keen intelligence he possessed a fund of wit and humor that delighted those fortunate enough to know him. For years it has

been his fancy upon each recurring birthday to write a verse or verses appropriate to the occasion. Perhaps it would be a letter of thanks for some little token of remembrance, or perhaps an expression of his own feelings.

The *Daily Gate City* of Keokuk writes of him: "Dr. Bowman always retained the fine bearing of a typical Southern gentleman. Tall and straight as an arrow always, despite the weight of many years. His intellectual faculties were unimpaired through all his long life. He had lived in Iowa for many years and his individuality was so marked, and his goodheartedness and cheer extended to all with whom he was associated, that his acquaintance was far extended. He was always proud of the State of his nativity and of his lineage. His career in life was straight and true, and his ideals high. Thus he lived and bore with him the good will of his neighbors, and dying he is mourned with a deep sorrow."

Dr. Joseph C. Benzinger, class of 1863, died at his home, 1906 E. Baltimore street, Baltimore, May 4, 1912, of heart disease, aged 68 years. Dr. Benzinger was a surgeon of Volunteers during the Civil War.

#### DISPENSARY CASES.

APRIL 1, 1911, TO APRIL 1, 1912.

<i>Clinics.</i>	New.	Old.	Total.
1—Surgical . . . . .	1754	5392	7146
2—Genito Urinary..	721	3033	3754
3—Medical . . . . .	1208	2309	3517
4—Eye and Ear....	740	1200	1940
5—Women . . . . .	604	1087	1691
6—Nervous . . . . .	286	1383	1669
7—Children . . . . .	605	843	1448
8—Stomach . . . . .	424	889	1313
9—Throat . . . . .	562	688	1250
10—Lung . . . . .	492	636	1128
11—Skin . . . . .	297	479	776
12—Orthopedic . . . .	40	40	80
13—Rectal . . . . .	41	38	79
Total . . . . .	7774	18,017	25,791
Total new cases.....			7,774
Total old cases.....			18,017

Grand total..... 25,791

JOHN HOUFF, M.D.,

*Dispensary Physician.*

# THE HOSPITAL BULLETIN

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Vol. VIII

BALTIMORE, MD., JULY 15, 1912.

No. 5

## A STUDY OF THE SYNCHRONOUS HEART BEAT AND RESPIRA- TION IN THE MUSTELUS CANIS.

(From the U. S. Bureau of Fisheries Labora-  
tories, Woods Hole, Mass.)

By ALBERT HYNSON CARROLL, M.D.

The following experiments, which I had not heretofore considered of marked physiological interest, appear in a new light since the publication of Hemmeter's important contribution to the comparative physiology of the circulation in the "dogfish," No. 1 (*Zeitschrift für Biologische Technik und Methodik*, Bd. 2, p. 236, Nov., 1911).

The friendly controversy between this author and Prof. Leon Fredericq which followed, No. 2 (*THE HOSPITAL BULLETIN*, May 15, 1912, page No. 1, Vol. 8), evidenced the lively interest manifested in the scientific world concerning any new contribution, and induces me to publish the experiments which led me to the discovery that the heart beat and respiration in the resting dogfish are concurrent, *i. e.*, have a ratio of "1 to 1."

Such a ratio has been reported in man in one case by S. W. Morris, No. 3 (*Archives of Internal Medicine*, 1911, p. 691. Synchronous Cardiac and Respiratory Rate).

The pathological picture was a complicated one. Here there existed an aortic mitral and tricuspid insufficiency, with hypertrophy and dilation accompanying passive congestion of the lungs.

The tracings from the jugular pulse and apex beat definitely eliminated the possibility of either heart block or a pseudo-bradycardia resulting from extra systoles. In this pathological state the intra-thoracic pressure determined to a great extent the heart rate.

This extreme case points to the urgent necessity for a thorough physiological training of the members of the medical profession.

Such training is necessarily based on knowledge gained through constant searching for new truths. A physiological phenomenon may be marked or obscure in a lower form. A comparative study broadens and strengthens our concept of these vital principles.

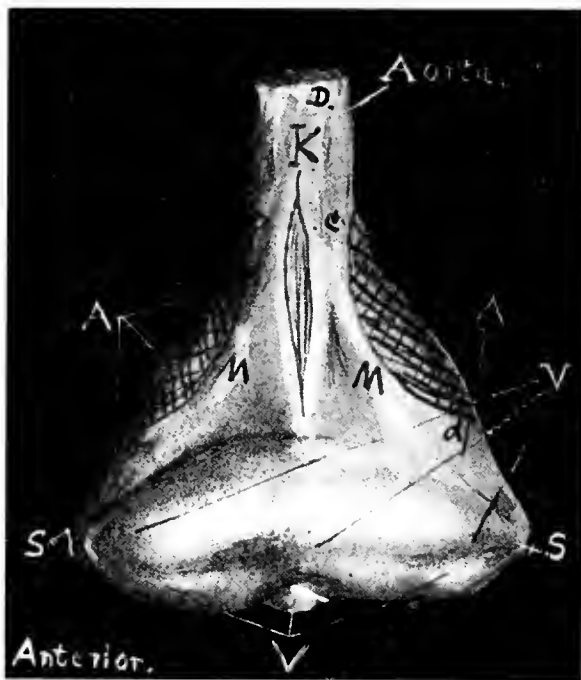
That the heart beat and respiration in animals bear a certain definite ratio to each other is familiar to all. Under normal conditions it is quite constant. It is about "4 to 1" in man. In the mustelus canis I have found it to be "1 to 1" under normal conditions. This unusual ratio is exhibited with great constancy.

The dogfish can be secured in unlimited quantities. It is admirably adapted for physiological experimentation. The blood stream can be either inhibited or lessened at will by vagus stimulation, or accelerated by stimulating certain areas which appear to be analogous to the sinus node of Keith and Flack. No. 4 (Altered Respiration and Its Effect on the Heart Beat) has been studied and the effects of various chemicals have been investigated, and will appear in a later paper.

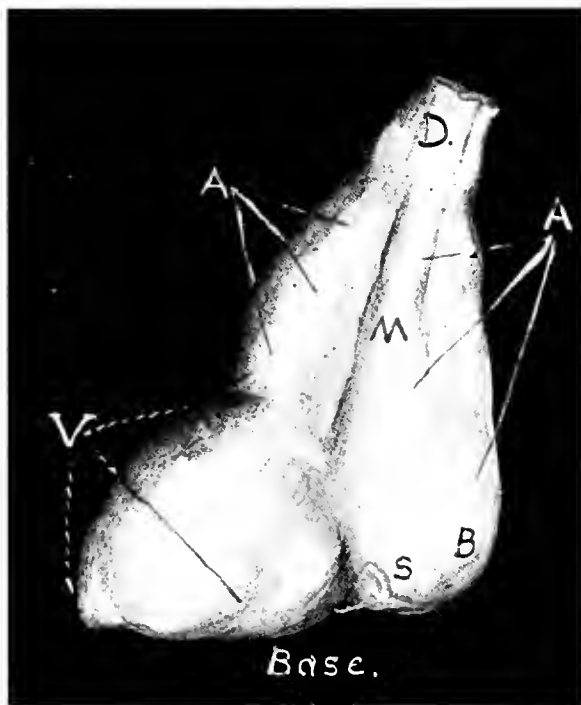
In earlier experiments on the heart beat and respiration of the dogfish, working with Dr. J. C. Hemmeter, we attempted to demonstrate a synchronous heart beat and respiration by placing a soft rubber ball connected with a tambour in the pharynx of the fish, by inserting a cannula connected with a recording mercury manometer into the pericardial cavity and recording the two tracings simultaneously.

Although records from each were obtained, nothing definite was demonstrated. The negative results were probably due to the physiological and mechanical disturbances caused by the bulky mass in the pharynx, and because the condition of sub-atmospheric pressure normally present in the pericardial cavity was undoubtedly destroyed. And perhaps partly because of the mechanical irritation to the heart as it beat against the cannula.

Later, however, I was able to demonstrate that this supposition was a correct one.



1—ANTERIOR.



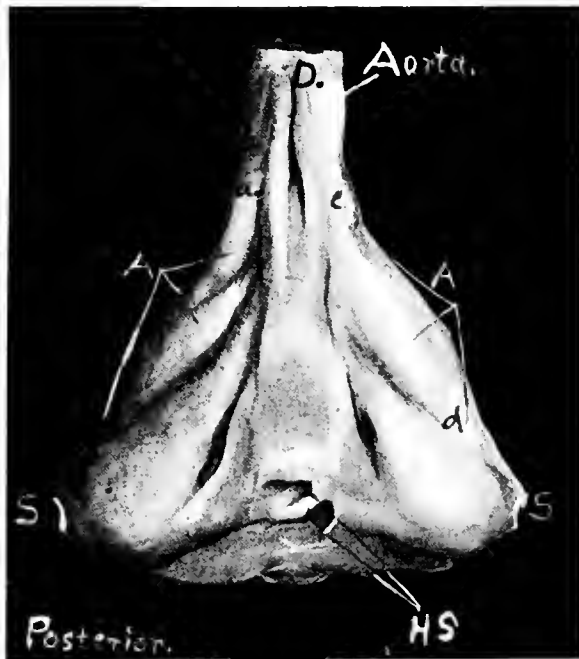
2—LATERAL.

It is not my object in this paper to investigate the physiology of the respiratory center or those

processes which bring about and maintain heart rhythm. Whatever the governing factors may be, the activity of these centers depends upon a "normal supply of balanced blood," as emphasized by Loeb and so clearly demonstrated by Linhard and others. No. 5 (J. Linhard, *The American Journal of Physiology*, May, 1911).

It appears that the balance is determined largely by the  $\text{CO}_2$  content, and that the excitability of the respiratory center toward the adequate stimulus to activity is governed by the O tension present.

The heart is the mechanical means or pump, the proper functioning of which determines the blood flow to the respiratory centers. Hence, if



3—POSTERIOR.

we alter the rate or force of the heart, we alter the quantity of blood pumped, and we expect to observe corresponding changes in the mechanical response of the respiratory muscles.

Similarly, if we experimentally alter the respiratory movements, we will alter the nature of the blood, and particularly will we alter the flow of the blood in the mustelus canis.

In a dogfish the pericardial cavity is analogous to the thoracic cavity in mammals. A portion of its walls are elastic. To the fixed and elastic portions are attached a series of muscles which shorten at each respiration. Each respiration is accompanied by a swallowing movement, which

alters the pull of these muscles at their attachments and markedly alters the negative intra-pericardial pressure. Each inspiration favors diastolic filling and expiration assists systolic emptying of the heart.

#### DESCRIPTION OF PERICARDIAL SAC.

Space prevents giving but a brief description of the tissues which act mechanically during respiration in bringing about a rhythmical alteration in the negative intra-pericardial pressure.

The drawings No. 1, No. 2 and No. 3, from a wax cast of the pericardial sac, show the anterior, lateral and posterior views of the dilated pericardium.

The heart-shaped portion of No. 1 is occupied by the ventricle V, and is firmly attached to and underlies the caricoid cartilage. The portions of No. 2 marked M and (a-b) (c-d) represent the attachment of the upper three of the five pairs of respiratory muscles, which are attached to the most movable portions of the pericardium. S. S. are lateral margins of the venous sinus where the blood from the lateral sinuses and the vagus fibres enter.

Fig. 2, "K" is the mesial line where the anterior margins of the auricle approach each other. It will be noted that the portion of the heart sac containing the auricle is much larger than the portion containing the ventricle V (about 3 to 1).

Fig. 3, H. S. are the points of entrance of the vessels from the abdomen. V ventricle. A auricular portion.

The pericardium lies between the clavicles and ventral to the esophagus. It contains the sinus venosus, (S. V.), No. 2 the auricle (A) and the ventricle (V). The caudal portion, or base (B), is occupied by the thin-walled but rather inelastic venous sinus and the auricle. The sinus is transversely placed, and is somewhat diamond-shaped. The cuvierean ducts empty into it laterally (S.S.).

Cranial to the sinus the sac is enlarged and rounded for the very thin and elastic walled auricle. Ventral to the latter portion is the somewhat rounded pyramidal portion, with its apex-directed caudad, in which lies the ventricle. The aorta D occupies the apical portion.

Leading from the pericardium is a large opening into the abdominal cavity, the pleuro-peritoneal canal. Two hepatic sinuses, placed close together mesially, enter the venous sinus from the abdomen and carry visceral blood to the sinus.

The base is somewhat concave, broader ventrally than posteriorly. The dorsal half is quite flexible, and is occupied by part of the auricle. The anterior walls near the base are rigidly fixed to the overlying cartilaginous pectoral arch. The lateral walls are also rigidly attached near the base.

There are several ways in which the pressure within the cavity can be altered. The lateral sides are rounded and approach others in the ventral mesial line. (K) No. 2. These walls also are flexible (a-b; c-d), and are capable of being moved inward and outward by the action of the muscles attached to them. Five peniform bilateral sets of muscles are attached to the sides of the sac (M), and extend to the gill arches. These are the principal inspiratory muscles. Each inspiration shortens these muscles, three pairs of which are connected with the movable portions of the pericardium, thus increasing its capacity.

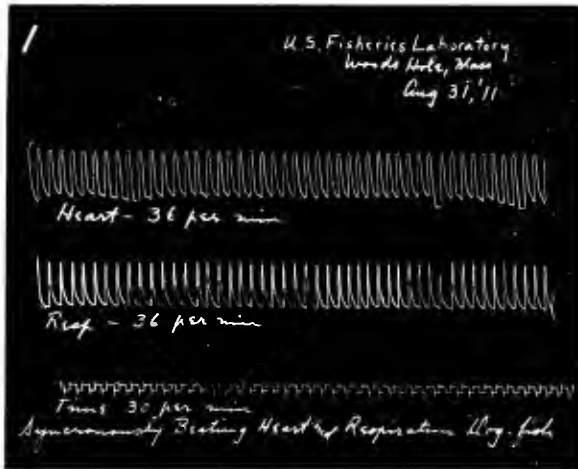
This pressure is also altered by each dilation and contraction of the heart chambers. A manometer connected with a cannula, carefully inserted into the sac through the pectoral arch, shows this to be a fact when the respiration is artificially stopped.

Again, the apex of the pericardium is drawn downward at each inspiration. This was shown by watching the movements of one end of a curved wire which had been inserted through a small opening in the pectoral girdle, the other end of which rested in the apex. When the respiratory group of muscles pull upward and outward on the sides of the sac, the acute apical angle is widened as the apex approaches the base, and the capacity of the cavity is increased.

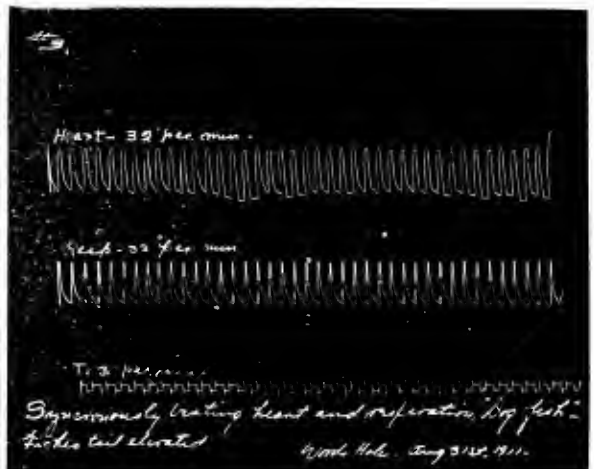
The result of this rhythmical alteration at each respiration and heart beat is the drawing into the sinus and auricle of the venous blood. A true estimation of the importance of this mechanical effect on the heart beat is only had when the extremely low blood pressure in the venous system in the dogfish is appreciated.

#### METHODS.

A medium-sized dogfish (80 cm. in length) was selected and placed in a tank of fresh sea water and allowed to become accustomed to its new surroundings. At the end of a half hour its respiration was counted. It was then placed in a box-like operating holder, ventral surface uppermost, and securely fastened with bands around the nose, just dorsad to the pectoral fins



NO. 1—TAIL ELEVATED.



NO. 3—TAIL AGAIN ELEVATED AND 1 TO 1 RATIO RE-ESTABLISHED. (THE DRUM HAD TO BE MOVED EACH TIME THE FISH WAS CHANGED IN POSITION IN ORDER TO READJUST THE WRITING LEVERS.



NO. 2—TAIL AND HEAD AT THE SAME LEVEL. BLOOD NOT ENTERING VENOUS SINUS IN SUFFICIENT QUANTITY TO FILL THE VENOUS SINUS AND TO STIMULATE IT TO "SET THE PACE." HEART 28, RESP. 55.

4, 5, 6—TRACING NOS. 1, 2 AND 3.  
SHOWING THE CONCURRENT HEART BEAT AND RESPIRATORY EFFORT—RATIO OF 1 TO 1.



and around the tail, replaced in the tank of water and another respiratory count made and recorded, first, with the dorsal surface uppermost; second, with the ventral surface uppermost; third, with the head elevated, and fourth, with it depressed.

In view of the later observations, it is interesting to note that there was practically no respiratory alteration following these alterations in position. (See table No. 1, Exp. 1.)

When it is necessary to operate, a light anesthesia, one just sufficient to last until the heart was exposed, was found to be better than deep anesthesia. Ten c.c. of a 10 per cent. alcoholic solution of chloratone in 1000 parts of sea water proved to be an excellent anesthetic, and was almost universally used.

When from shock or from some other unexplained cause the heart of a dogfish or sand shark was found to exhibit fibrillary contractions, a mild stimulation of the vagus for a few seconds would usually restore it to its normal rhythm. This was interesting, since it recalled that Garrey, No. 6 (Walter E. Garrey, *American Journal of Physiology*, 1892, Some Effects of Cardiac Nerves Upon Vent. Cont.), experimenting with dogs' hearts, found that vagus stimulation only met with a *small percentage of success*, and then when the dogs were in a very poor condition.

#### TO EXPOSE THE HEART AND THE VAGUS NERVES.

No. 7. For a detailed description of the technique of exposing the heart and vagus nerves as developed by Hemmeter and the author, see *Zur Technik von Vagusexperimenten am Scylium*. *Zeitschrift für Biologische Technik und Methodik*, Nov., 1911, J. C. Hemmeter.

A curved incision, reaching from one-fifth gill slit to the other, is made through the skin, across and above the pectoral arch. From its center a forward incision is made, extending well up toward the mouth. Starting at each dorsal crevice of the fifth gill slit an incision is made posteriorly to the lateral lines, and then carried forward along the lines 3 to 5 cm. The lateral skin flaps are reflected. Blunt dissection is employed if it is wished to expose the underlying vagus nerves.

The "ramus cardiacus" is found on each side entering the cuvierian duct or sinus, which opens into the pericardial sac. The ventral skin flaps are dissected back and the cartilagenous pectoral arch laid bare. The dissection is then carried anteriorly until the pericardium is reached.

The heart is exposed by making a small tri-

angular opening centrally through the caracoid cartilage. Great care is used to avoid trauma to the heart, which almost completely fills the pericardium. The opening is then extended forward about 1 cm., sufficiently to expose the heart. The box is again placed in the sea water tank with the mouth and gills submerged. If heart tracings are desired, the apex of the ventricle can be picked up with small blunt forceps and a thread tied around the tip of it. Another thread is attached to the skin by a sharp hook above the third gill arch and somewhat laterally to record any respiratory movement. These threads are connected to the recording levers of a kymographion.

August 28, 1911. *Experiment No. 1. Effect on Respiration by Changing the Position of the Fish:*

A small fish was secured in the holder and the holder immersed vertically with the fish's head uppermost and just beneath the surface of the water. Respiratory rate varied from 45 to 47 during the following hour; 10 A. M., respiration 46; 10.30 A. M., respiration 45; 12 M., respiration 44; 5 P. M., respiration 46; July 27, 9.30 A. M., respiration 46.

The fish was now allowed to swim freely in the tank, and appeared perfectly normal. It was again secured and placed in the holder in the water tank, head downward, overnight: 9.40 A. M., respiration 48; 10.30 A. M., respiration 48; 12 M., respiration 46; 6 P. M., respiration 47.

The fish was then placed laterally in the water, ventral surface downward. Respiration was 47, and remained constant for an hour. It was next turned over with the dorsal surface downward. The respiration remained at 47. Position evidently affects the rate of respiration but little.

Exp. No. 1. Table 1.	Fish No. 1.	Fish No. 2.	Fish No. 3.	Fish No. 4.
Dorsal surface up....Resp.	45	40	32	29
Ventral surface up....Resp.	47	40	31	30
Head up.....Resp.	46	41	32	33
Tail up.....Resp.	48	40	33	34

August 31, 1911. *Experiment No. 2. To Discover the Ratio of Respiration to Heart Beat in the Mustelus Canis:*

A fish was lightly anesthetized and secured in the box-like holder. A very small opening was made through the pectoral arch, just sufficiently large to observe and count the heart beats. The holder was now submerged in the sea water tank and respiration and heart rate counted. The

heart beat only once in every two respirations:

Respiration 9 A. M., 49; 9.15 A. M., 48; 10.30 A. M., 52.

Heart 9 A. M., 25; 9.15 A. M., 24; 10.30 A. M., 26.

Any violent effort to escape would be followed by an irregularity of both breathing and heart beat. It was observed that at times a *firm pressure* when holding the fish quiet *on the abdomen* would cause a short period of synchronous breathing and heart beating, due to an increased flow of venous blood into the heart from the large abdominal veins.

It now occurred to me that since the opening of the pericardial sac had negated the normal sub-atmospheric intra-pericardial pressure, that the blood was not returning in sufficient quantity to the venous sinus, and that the local mechanical stimulating effect normally due to its pressure was altered or lacking.

I elevated the tail of the fish, and in this way "*allowed gravity to play the rôle normally enacted by the sub-atmospheric intra-pericardial pressure in filling the venous sinus,*" making an angle of about 20 degrees with the surface of the water.

Almost at once the *heart rate was increased*, equaling the number of respirations per minute, each auricular diastole immediately occurring after the closure of the gill clefts.

The opening in the pericardium was enlarged. The apex of the ventricle was picked up by small blunt forceps and a thread tied around the tip of it. Another thread was attached to the skin by a sharp hook above the third gill arch. The threads were connected to the recording levers of a kymographion. In a few moments the heart beat and respiration ratio became "1 to 1." (See tracing Nos. 1, 2, 3, Exp. 2.)

July 25, 1911. *Experiment No. 3.* Both vagus nerves exposed and pericardium opened, showing venous sinus.

"I" shows inhibitions of auricle after stimulating right vagus.

"I'" shows inhibition of auricle after stimulating left vagus.

A and A' = auricle accelerated by stimulating certain as yet not precisely located areas in the venous sinus.

Too strong a current causes inhibition due to escaped currents.

July 26, 1911. *Experiment No. 4.* Right and left cardiac branch of vagus exposed and peri-

cardium opened. Auricle and ventricle connected with recording levers. Times 32 per min., showing that both auricle and ventricle can be accelerated as well as inhibited by stimulating the vagus and the "accelerator areas" in the venous sinus.

It will be evident from a study of the tracings that this acceleration of the auricle and ventricle is a true acceleration, and not a fibrillation. The V. S., which apparently contains in its walls certain as yet illy-defined accelerator fibres, is the pacemaker for the beat. It always beats first in a strong heart, *i. e.*, one in good condition. Again, I have cut both vagus branches, singly and simultaneously, and noted that there was no alteration of the heart beat or the blood pressure. No accelerator nerve or branch of the sympathetic nervous system has been found leading into the heart tissue by various earnest biologists and comparative anatomists. It appears to me that I have demonstrated that the heart beat originates in the V. S., and that a balanced blood, at a *definite pressure* and quantity, determines the rate of the heart beat by its mechanical as well as perhaps its local chemical action on these pace-making and accelerator venous sinus areas.

The rigid structure of the cartilaginous walls of the vessels or channels leading into the V. S. laterally precludes the possibility of the beat originating in them.

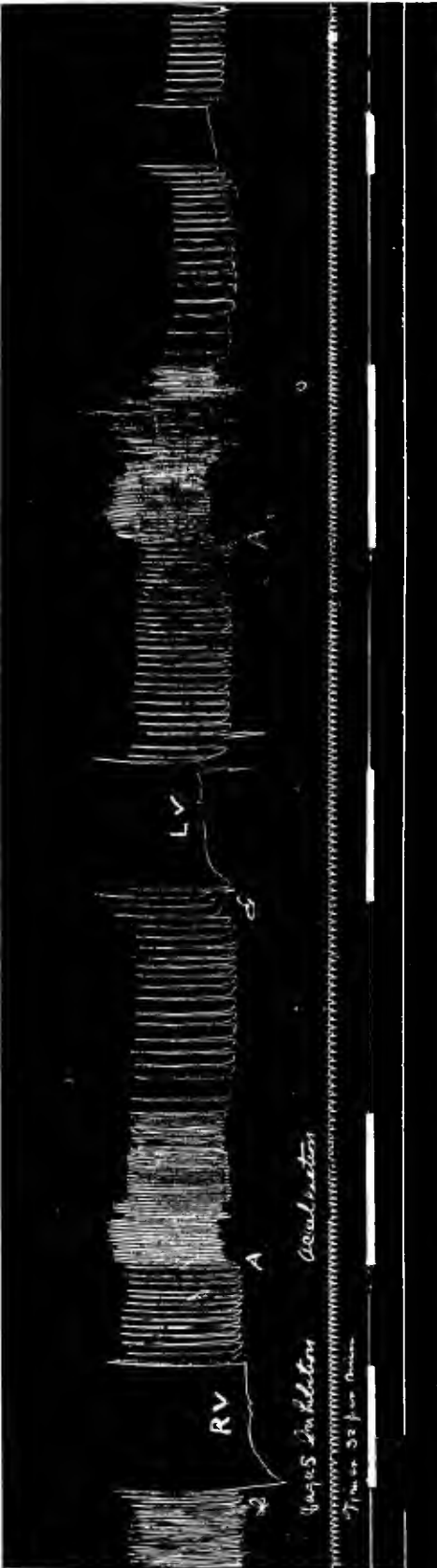
#### CONCLUSIONS.

First—The negative intra-pericardial pressure is altered markedly at each respiratory effort in the *mustelus canis*, but is always a negative pressure; otherwise, the low blood pressure in the venous system would not cause the blood to enter the V. S.

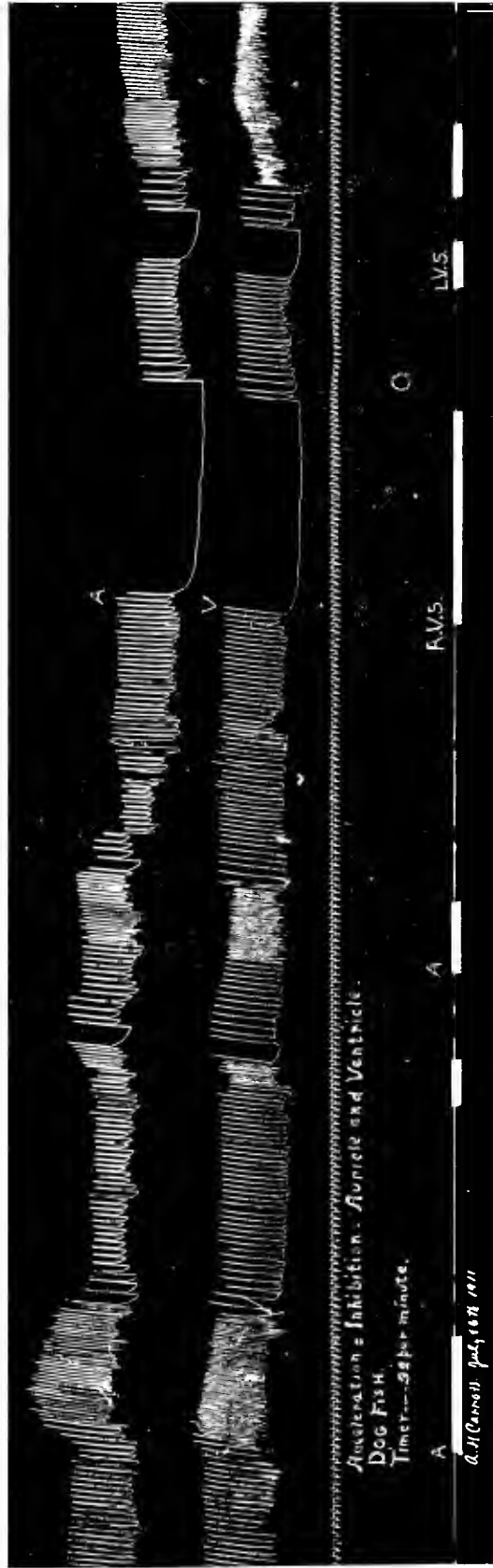
Second—Without a proper amount of fluid, mechanical as well as a possible local chemical stimulation to a normal beat is lacking.

Third—Accelerator fibres do not appear to exist in the main vagus trunks, and none have been observed macroscopically to enter the heart tissue by way of the venous channels, but there are certain areas in the walls of the V. S. which positively respond to stimulation with a weak current.

NOTE.—I wish to thank Dr. Hemmeter for encouragement which led to the observing of these phenomena, and the University of Maryland Laboratories for the use of apparatus, and Dr.



7—Tracing No. 2, Exp. No. 3. Tracings from ventricle, Stimulation of right vagus (R. V.) and left vagus (L. V.) with a weak induced current, using a Harvard apparatus commutator switch. In each case the current was cut off as an escape occurred in the auricle. Note rapid recovery from inhibition and slow recovery from acceleration. In this experiment the head of the fish had not been submerged, and, as is usually the case, the blood stream contained numerous bubbles. Although the heart was beating strongly it could not have been called a really normal heartbeat.



8—Acceleration of both auricle and ventricle following the stimulation of certain areas of the venous sinus with a weak induced current. Also vagus inhibition of both auricle and ventricle.

Francis B. Summer, Director of the U. S. Fisheries Laboratories, Woods Hole, for an abundance of experimental material.

906 N. Calvert St., Baltimore.

## IMPROVED TREATMENT OF TUBERCULAR BONE ABSCESES.\*

By W. SAULSBURY NIBLETT, M.D., 1911.

Since the recognition of tubercular abscesses and sinuses the evolution of the treatment has been more or less in a chaotic state, and is far from satisfactory. Many methods have been suggested and tried, but the attempt to go into this subject very deeply is confusing and almost hopeless as to the enumeration of the various methods of treatment; therefore, the object of this paper is in the nature of a small contribution of our experience at the Kernan Hospital and the Hospital for Crippled Children, and while we all agree that the subject is as yet meager, we will give the methods of treatment that have come under our own observation.

It might be well, before we consider the treatment to briefly summarize the pathological changes that take place in the development of tubercular abscesses and subsequent sinus formation.

The cause of the disease has been known since the time of Koch, but the exact pathology is confusing, this being especially so in joint tuberculosis. The tubercle bacillus enters the spongy portion of the body of the vertebra and in the marrow of the spongy portion of the ends of long bones, and not the shaft. As you all know, there are various theories as to why tuberculosis occurs in the ends of long bones and not, as a rule, in the shaft. Some say the vulnerability is due to the arrangement of the blood vessels—that is, the lack of anastomosis in the end arteries—and that small emboli of a conglomerated mass containing the tubercle bacillus from some other focus lodge in the end arteries around the epiphysis of long bones.

Ely of Denver advances a theory that it is due to the fact that we find lymphoid marrow, or red marrow, in the end of long bones, and this gives a foothold for tuberculosis. As there is more red marrow in the bones of children, this explains

why we see more bone tuberculosis in children than in adults; but joint tuberculosis is rare in children under one year of age.

The blood or lymph is the medium through which the tubercle bacilli are conveyed to the bone from some other focus. It may enter by direct extension. After the tubercle bacillus enters the bone it sets up a low grade of inflammation, causing a small spot of hyperemia, probably due to the toxin formed by the organism. This forms a small granulomatous area in which may be found the characteristic yellow or gray tubercle, which may be composed of one or more giant cells having several nuclei, surrounded by a mass of epithelioid cells, and these, in turn, surrounded by lymphoid cells.

This area becomes larger and opaque, and is surrounded by a hyperemic area which spreads by peripheral extension, and results in tubercular granulation tissue. During the later or reparative stage of this process the area becomes less vascular, and is converted into a dense fibrous tissue, but in the center of which degeneration and necrosis take place. This is called caseation. If caseation takes place without suppuration, it is called "caries sicca," but if it takes place with suppuration it is known as "caries necrotica," it being secondary or consecutive, and will point in the line of least resistance, burrowing its way by the weight of the contents of the abscess, infecting the soft tissues as it goes, thus carrying the tubercular disease into different parts, rendering the treatment of the diseased soft tissues equally as hard as that of the original focus.

An area of caries necrotica may become walled off and result in a cloaca or become calcified; but, as a rule, abscesses and subsequent sinus formations are frequent complications, indicating the destructive character of the osteitis and the low grade of resistance on the part of the host. A tubercular abscess and sinus is surrounded by a pyogenic membrane, that is, a wall of granulation tissue filled with tubercles if the tissues are vulnerable to tuberculosis and are secondarily infected; if not, they will not be found.

Bearing these points in mind, one will be better able to treat tubercular abscesses and sinuses. Among the various forms of treatment may be mentioned the following: Evacuation of the abscess and immediate closure; evacuation and drainage; evacuation and injection of iodoform-glycerine; evacuation and swabbing out with car-

\*Read before the Baltimore County Medical Association, May 15, 1912.

bolic acid, followed by alcohol; washing out with hydrogen peroxide or 40 per cent. formalin, iodoform ether, zinc chloride solution, tincture of iodine; evacuation and injection of Beck's bismuth paste or injection of chalk powder and vaseline; vaccines in mixed infections, and, finally, tuberculin used both locally and systemically; the new tuberculin used systemically and the old tuberculin used in abscesses or sinuses.

One will readily conclude from the numerous methods here mentioned that the use of any one of these has not proved entirely satisfactory in the hands of orthopedists in all cases. We have used all of the above methods, but have found by experience that better results are obtained by the following treatment: We must bear in mind that nature is engaged in a local, germicidal warfare, and well-directed assistance in building up the general condition of the patient will enable her to conquer. Remember to treat, first of all, the primary focus by the best means possible, and that the treatment of the abscess is secondary: therefore, not only orthopedic, but all hygienic measures must be enforced, such as sufficient sleep, fresh air, sunlight, good, nourishing food, proper clothing, etc. All of these are most important adjuvants, but too much stress cannot be laid upon the importance of good food, fresh air and sunlight, as these are the most important agents required not only in phthisis, but in bone tuberculosis.

Other measures should be employed to improve the general conditions, such as tonics and alteratives, which must be selected according to each individual case. We have had good results from using olive oil, hypophosphites, strychnine, tincture of nux vomica, potassium iodide, tincture of ferric chloride and syrup of the iodide of iron.

Now, as to local treatment, we have found that the existence of a tubercular abscess does not necessitate immediate evacuation, so we find that the expectant treatment, combined with thorough mechanical treatment, often yields good results. If the abscess is very large and deeply placed, there being no signs of pressure symptoms, we have found that if the part is put at rest by traction and fixation, and the patient allowed plenty of fresh air, sunlight and good food, the contents of the abscess will become absorbed or the caseous material will become encapsulated. Therefore, we religiously discourage immediate evacuation of the abscess unless it has signs of second-

ary infection, because an abscess that is opened is not only most prone to secondary infection by pyogenic cocci from the skin and hair follicles if left open for 24 hours, but may cause a dissemination of tubercle bacilli by way of the blood or lymph, setting up miliary tuberculosis or meningitis, or it may cause the formation of a sinus which will probably not only discharge as long as the disease is active, but is "the gateway by which death so often enters."

In cases in which the patient has a great deal of pain, due to pressure on nerves, blood vessels or bowels or interference with digestive or respiratory functions, we advocate incision, evacuation of the abscess and immediate closure. Under no circumstances do we allow an abscess to be left alone when the skin is becoming reddened from tuberculous infiltration, because it will ultimately break down and most likely become secondarily infected.

All abscesses secondarily infected should be opened at once, swabbed out with carbolic acid, followed by alcohol, which will destroy the remaining tubercular germs and the secondary infection. There should be no fear of absorption by using pure carbolic acid, followed by alcohol, for it unites with the albuminous material, forming an albuminoid, which is absorbed by the lymphatics and destroys the bacteria beyond the focus of the disease.

In some convalescent cases of bone tuberculosis, where the focus is circumscribed and easily accessible—for example, in the condyles of the femur—erosion may be done, always by the use of an Esmarch bandage and a tourniquet. The cavity is swabbed out with tincture of iodine and filled with the following mixture: Yellow wax, one part; lanolin, five parts; bismuth subnitrate, 15 grains to an ounce of the mixture, after which the incision is closed. We believe this procedure has, by direct extension, saved many joints from infection. This does not, of course, apply to tubercular foci within the joint or vertebrae.

Secondary abscesses recurring after once being opened, evacuated and closed are opened the second time, evacuated and the cavity filled with a mixture of precipitated chalk powder and vaseline or with Beck's bismuth paste. We have had good results from most cases by the use of this method of treatment, generally two or three injections being necessary.

There are certain cases, however, that refuse

to heal under any local treatment, and ultimately result in the formation of an obstinate sinus. Here we have a rather difficult condition to treat, but, again, we have greater success by the use of Beck's bismuth paste or by the use of a chalk mixture; but in the use of the former one has to be somewhat cautious to guard against bismuth poisoning, although we have had only one case poisoned by bismuth. As some patients seem to have a marked idiosyncrasy for the substance, we are using the chalk mixture almost exclusively.

Lately we have been using old tuberculin locally with fair results. It is very stimulating to the sluggish granulations, and converts the creamy pus into sero-sanguinous pus. After two or three injections the sinuses appear healthy and the discharge is markedly decreased.

The technique is very simple, and consists of the injection of about 120 m. of 1-500 old tuberculin into the depths of the sinus by means of a small, soft-rubber catheter, which is then withdrawn as one or more injections is made, in the endeavor to bring the tuberculin into immediate contact with the walls of the sinus.

After three or four injections the strength of the tuberculin is increased from 1-500 to 1-250, or even stronger. This is governed by the reaction, both local and systemic. The injections are given biweekly. Generally there is some systemic as well as local reaction. Frequently the patient's temperature may reach 101-101.5°, with marked lassitude, but this is less marked after the first two or three injections, and usually disappears entirely after subsequent treatments. Great care must be taken to prevent the use of strong tuberculin, as it will cause a rise of temperature.

Our feeling in the matter is that the sooner we get the sinus closed or thoroughly plugged—aside from the treatment of the granulations with the tuberculin, or some other substance, to stimulate the walls of the abscess or sinus—the better it is for the patient.

Kernan's Hospital.

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### IN MEMORIAM

At a meeting of the Regents of the University of Maryland on June 19, 1912, called on the occasion of the death of the HONORABLE BERNARD CARTER, LL.D., the following minute was adopted and placed upon their records:

The Regents of the University of Maryland deplore deeply the loss which the institution under their charge and themselves personally have sustained in the death of the HONORABLE BERNARD CARTER, LL.D., Provost of the University.

Succeeding the late Severn Teackle Wallis in the office of Provost 18 years ago, Mr. Carter manifested during that whole period the deepest interest in the welfare of the University. While it would have been natural that from his own professional studies he should have bestowed his special thought upon the school of law, in which he had been at one time an instructor, yet in the admirable addresses which he made to the assembled classes of students in the several schools of the University on the commencement occasions he showed always a full appreciation of the nature and importance of their respective studies.

From his experience in his own profession of the law, in which he had attained the highest distinction and had won by the consent of all and enjoyed for approximately a quarter of a century the position of leader of the bar, he knew the difficulties and discouragements which the young votaries of science encountered in the early periods of their careers. From this knowledge he manifested by his words and by his looks a deep and sympathetic interest in the students before him, and he showed them by his wise counsels how their trials were to be met and overcome. And thus his words of encouragement and stimulation seemed a benediction upon the work in which the young graduates of the University were about to engage.

From early life Mr. Carter had taken a deep interest in the work of the church to which he was attached, and for this reason, and especially from his knowledge of ecclesiastical history and law, he was for many successive years elected a delegate to the Diocesan Convention of Maryland and on several occasions a deputy to the Triennial General Convention of the Episcopal Church, of both of which bodies he was always regarded as a most influential and valuable member.

In all of these fields of labor, that of the councils of the church, that of his own profession and that of the academic work of the University of Maryland, he was governed and guided by his earnest and devoted Christian faith. As was his faithful and conscientious labor, so be his reward.

DANIEL BASE,  
Secretary.

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JULY 15, 1912.

## UNIVERSITY LOSES HER PROVOST.

The news from Naragansett Pier, R. I., June 13, 1912, that Bernard Carter, Provost of the University since 1894, had died suddenly that morning, was a great shock to University men and Marylanders in general. Mr. Carter had not been well for some months, but his death was wholly unexpected. He had gone to Naragansett but the day previous to that upon which he was stricken, and was anticipating a pleasant vacation there.

Bernard Carter was born in Prince George's county July 20, 1834, and is descended from the Carter family of lower Virginia and the Calvert family of Maryland. His father, Charles Carter, was the son of Bernard Moore Carter and grandson of Charles Carter, of Shirley, on the James River. Robert Carter, who was known as "King" Carter of colonial times, was a direct ancestor. Bernard Carter was a grandson of "Light Horse" Harry Lee and first cousin of Gen. Robert E. Lee. His mother was Rosalie Eugenia, daughter of George Calvert, son of Benedict Calvert, and grandson of Charles, the sixth Lord Baltimore. Mr. Carter was also a direct descendant of Rubens, the painter, through his great-grandfather, Henry J. Stier d'Aertzlaer of Antwerp, Belgium, who fled to this country in 1784 to escape scenes and dangers of the French Revolution, but returned in 1805, when Belgium was annexed to France, to prevent the confiscation of

his large landed estates. His daughter married George Calvert.

Bernard Carter graduated from St. James' College, Washington county, Maryland, in 1852, receiving his degree of master of arts from that school three years later. He then studied law at Harvard, where he graduated in 1855. He then came to Baltimore, and was admitted to the bar, entering the office of J. Mason Campbell. He always lived and practiced here, and soon became a leader of the bar of the State. In 1865 he was admitted to the bar of the Supreme Court of the United States, his first argument before that court being in the case of the steamer "Louisiana," reported in "Wallace's Reports." He was always a corporation lawyer, having immediately after his admission to the bar evidenced a distaste for criminal suits. At the death of J. Mason Campbell he was appointed chief counsel of the Pennsylvania Railroad Co. and its subsidiary branches, and remained with it throughout its growth from a small local transportation line to its present influential position, waging its battles in the local courts, the Court of Appeals, in the Federal, District and Circuit courts, and the United States Supreme Court.

In 1861 he was the nominee of the Democratic party for State's Attorney of Baltimore, and in 1864 for Attorney-General of the State. He was not elected, owing to the strong Republican trend of those days. He served in the First Branch of the City Council in 1869 and 1870, and as chairman of the Ways and Means Committee did much toward the economical building of the present City Hall. In 1867 he was a delegate from Baltimore to the Constitutional Convention of the State, and through his work at that convention was appointed a member of the committee on revision and compilation, to which were referred all sections of the Constitution which had been adopted for arrangement, revision and correction before being finally passed upon. In 1895 he was counsel to the Board of Police Commissioners. He was often urged to run for Congress, but repeatedly refused. Once he was induced, against his own better judgment, to be a candidate for the United States Senate, but failed of election. He was City Solicitor from 1883 to 1889, and again in 1900, but only remained in the office a few months, as its duties conflicted with those of a corporation whose counsel he was.



Mr. Carter married April 20, 1858, Miss Mary B. Ridgely, daughter of David Ridgely, of White-marsh, Baltimore county, Maryland, and had 12 children, of whom nine, three daughters and six sons, are living. Charles H., Bernard M. and Shirley were associated in law with their father; John Ridgely Carter is a member of the diplomatic service; George Calvert Carter entered the ministry and is rector of St. Andrew's Protestant Episcopal Church of Washington, and Julian Carter is a well-known real estate man of Baltimore; Mrs. A. Robinson White, of Relay, Mrs. Ernest Law, of Philadelphia, and Mrs. Arthur Lyman Fiske, of New York, the three daughters, are equally well known. Mrs. Carter died some years ago. Mrs. Fiske and Rev. George Carter and Bernard M. Carter accompanied their father to Newport and were with him at the time of his death.

He was buried from his Baltimore home, 1212 Eutaw place, on Saturday, June 15, 1912, at 11 o'clock. Services were held at Old St. Paul's Church, of which he was a vestryman and active member, having taken part in all of the ecclesiastic discussions of the State, and were conducted by the rector, Rev. Arthur B. Kinsolving, and the rector emeritus, Rev. J. S. B. Hodges. The honorary pallbearers were Chief Justice J. Hunter Boyd and Judge Henry Stockbridge of the Court of Appeals, Chief Judge Harlan of the Supreme Bench of Baltimore, Judge John C. Rose of the United States District Court, Francis J. Gowan of Philadelphia, general counsel of the Pennsylvania Railroad; Gamble Latrobe, general local agent of the Pennsylvania Railroad, and John J. Donaldson, James L. McLane, Arthur W. Machen, George C. Wilkens, William A. House, John S. Gittings, Michael Jenkins, Douglas H. Thomas, William Shepard Bryan, F. H. Bethell, Dr. Cary B. Gamble, Jr., Robert Crane and Robert W. Johnson. The active pallbearers were the five sons who were able to be here (John Ridgely Carter being in London at the time) and a nephew, Carter M. Bowie. Interment was in the family lot in Greenmount Cemetery.

Bernard Carter became a professor in the Law School of the University in 1878, and in 1895 became Provost. His lectures were noted, and the University claimed him among the many "giants" who have honored her halls. A giant in stature and mind, he loomed large in the legal

horizon of his day. Entering the legal world, as he did, in a day when telephones and telegraphs and typewriters were unknown, when the entire profession of the State numbered but about 125, and when Maryland was noted for its able lawyers, he remained a representative of that day until he died. Progressing with the progress of the times, he never lost his old-school manner or his old-school method of grappling with details. He was always courteous, and his kindness to timid witnesses was proverbial. His self-control was remarkable, and he was never known to take an unfair advantage. He was loved and revered by the younger lawyers and looked up to by all.

In politics he was a Democrat, and though he gave his time almost entirely to his profession, occasionally he consented to use his talents in behalf of his party and made several telling speeches in favor of Democratic principles.

Bernard Carter's name has shed luster upon the University, even as the names of Roger B. Taney and Severn Teackle Wallis did in that elder day when they, as provosts, guided its destinies. It is fitting that the men who stand at the head of our venerable institution should be, as they have always been, the men at the top rung of Maryland's bar and men who are regarded as the foremost citizens of the State of Maryland. We await with interest the appointment of Mr. Carter's successor, and hope that he will be given a freer hand in the upbuilding of the University.

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## THE STEAM ROLLER AND THE MEDICAL COLLEGES.

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We have heard much of the steam roller as applied to practical politics of late, and Chicago has been especially prominent in the enforcement of steam-roller methods in the selection of candidates for high governmental offices. The steam roller is also being applied to the medical colleges, with the object of crushing out of existence a large proportion of those that are now in more or less active operation. This juggernaut also operates in and from Chicago through the Council on Medical Education of the American Medical Association. While the methods are drastic, the writer is not inclined to quarrel with the intent of the Council, which is to reduce the number of medical schools in the United States about one-half and to improve those that remain. Among



the edicts that have been handed down is one that is in the line of progress, though it will doubtless inflict serious injury to many institutions. This is a ruling passed at the recent meeting of the Association at Atlantic City that after January 1, 1914, all schools wishing to be classified in Class A must require a year of college work in chemistry, biology and physics, with one foreign modern language, in addition to a completed four-years' high-school course. This rule goes into effect a year and a half from now; hence time will be given to notify prospective students of the increased requirement. The University of Maryland will loyally comply with this ruling at the appointed time.

The demand is also made by the various organizations that have authority to do so that the laboratory branches be filled by full-time, expert, salaried teachers, and our school is now reorganizing its staff in such a manner as to comply with this requirement. This means that the clinical teachers will receive no salaries, and that the revenues of the school will be devoted to the scientific departments. The battle is not always to the strong nor the race to the swift, but it is going to be a very hard matter for the weak and the slow medical schools to survive in this struggle. The question that concerns us is, Can we survive? We believe we shall, but only by the self-sacrificing labors of the teachers and the financial aid of our alumni and friends. We again ask the assistance of all of you in raising the \$100,000 pathological fund.

## CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1868.....	10 00
1871.....	35 00
1872.....	70 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	35 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00

1892.....	150 00
1893.....	15 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	25 00
1900.....	215 00
1901.....	240 00
1902.....	305 00
1903.....	315 00
1904.....	145 00
1905.....	210 00
1906.....	165 00
1907.....	110 00
1908.....	10 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to July 1, 1912..\$10,056 50

## NEW SUBSCRIPTIONS IN JUNE.

Dr. H. U. Todd, 1908.....	\$10 00
Dr. W. F. Sowers, 1906 (second contribution).....	10 00
Dr. J. Holmes Smith, Jr., 1905.....	10 00
Dr. H. J. Maldeis, 1903 (second contribution).....	15 00
Dr. Chas. W. Famous, 1901.....	5 00
Dr. Nathan Winslow, 1901 (third contribution).....	50 00

Total.....\$100 00

## WHO SHALL IT BE?

Whether the University of Maryland is to stand still or advance is the momentous question the answer to which is awaited with bated breath by alumni, friends and well-wishers. The River Jordan must be crossed, the bridges of the past burned so that there may be no turning back, if the venerable institution is to occupy its erstwhile commanding position among its sister-institutions.

The question which is at present uppermost in the thoughts of the alumni is, Who shall be the Moses to lead the University of Maryland into the chosen land and hold her there? If words made institutions of learning, we would be well

founded; but we know that actions only count, and that to insure actions we must have a leader of broad mind, one endowed with the ability to attract men, a man vested with authority to seize the helm and guide the ship into a safe harbor. The death of Provost Carter forces some action upon the University, and affords a golden opportunity to once and forever remedy the anomaly of an institution conducted by a head without authority to act for her welfare. If the occasion is permitted to pass, and the same old lines are pursued without change, then those who today hold the destinies of the University in trust will be held culpable by future generations, and their motives will be adjudged as selfish and their viewpoint as narrow. The question before the University today is one which eliminates persons and holds up for view only the interests of the University and her future, and personal ambitions and personal losses alike must be forgotten and the upbuilding of the University must be the only end sought.

The alumni hope that there are enough progressives in the Board of Regents to read the reactionaries, if there be any, out of its body. Rocks are ahead of us if a change be not effected. The life of the institution is hanging in the balance. The predatory rich are exerting every means to force us to close up. This is no mere ranting, but an actuality. It is reported that Dr. Griffith Davis, an alumnus of our institution, while in conversation with Dr. Franklin P. Mall, professor of anatomy in the Johns Hopkins University, said there is room in Baltimore for two medical schools only, whereupon the following reply was evoked: "There is only room for one—the Medical School of the Johns Hopkins University. Let the other schools combine. We (the Johns Hopkins) intend to crush them all." Such, fellow-alumni, members of the Faculty of Physic, members of the Board of Regents, is the state of affairs. We are surrounded by our enemies. Are we going to stand idly by and see the good old ship go down? Don't for one moment think it unsinkable, for it is not. Still, it is hard to believe that an institution which turned out Carroll, Blue and Carter has reached the end of its usefulness. As a matter of fact, the University of Maryland ought to be serving the State and nation many years after all of us of today have been called before our Master. However, in order to insure continued existence and usefulness, the Board of Regents must do its part. They must seize every

opportunity to advance the material as well as educational interests, and today offers them an occasion fraught with possibilities—the appointing of a Provost—a Provost in being as well as name. To be or not to be—that is the question; whether the University of Maryland is going to die a slow and agonizing death or is to take on renewed life and vitality is the absorbing question which is agitating the minds of all true friends of our institution. The answer will be read in the name of the man who is appointed Provost.

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## ABSTRACT

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### THE PNEUMOCOCCUS IN SURGERY.

Dr. Arthur M. Shipley, class of 1902, in a paper read before the Medical and Chirurgical Faculty of Maryland, April 24, 1912 (*Journal A. M. A.*, May 25, 1912), said:

"For many years the pneumococcus was looked on as being of interest only to the internist, but there is scarcely any tissue in the body immune to its attacks and, as a pus-producer, it ranks next to the well-known pyogenic organisms. Therefore, it frequently becomes the cause of distinctly surgical conditions. Some of the serious complications of pneumonia, such as empyema and abscess of the lungs, are often due to the pneumococcus. Other conditions are thrombophlebitis, arthritis, osteomyelitis, parotitis, cholangitis and cholecystitis, mastoiditis, puerperal sepsis, and, especially, pneumococcic peritonitis. The sources and avenues of infection still remain uncertain. The peritonitis may be a part of a general sepsis, it may be secondary to an infection elsewhere, or it may be primary. Clinically the peritonitis is often secondary to pneumonia. In these cases the weight of evidence is in favor of the bloodstream as the carrier of the infection. Pneumococcic peritonitis must not be confused with lobar pneumonia with referred abdominal pains and tenderness. The morbid anatomy of this type of peritonitis closely resembles that of the pleura under like conditions. The pus is rather characteristic. It is odorless, yellow or yellowish-green and contains flakes of fibrin. The onset is sudden, with a sensation of chilliness and, perhaps, a rigor. Diarrhea often precedes the attack and there is great pain, vomiting, prostration, leukocytosis, rapid elevation of temperature, and a rapid small pulse. Tympanites is usually not marked, the abdominal wall being rigid and

scaphoid. A characteristic doughy feel has been spoken of. The progress of the disease is more rapid than that of other types of peritonitis. The prognosis is extremely grave, few patients having recovered. The treatment is that for suppurative peritonitis—nothing by mouth, rapid operation, little anesthetic, pelvic drainage and normal salt solution by the rectum.

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## ITEMS

We are indebted to Old Maryland for the following locations of the class of 1912 in as far as is at present known:

Hebrew Hospital—Benjamin Newhouse, pathologist; David Silberman, assistant resident surgeon; Harry Herman Rich, assistant resident physician.

Springfield, Mass.—Henry Zimmerman.

Santiago, Cuba—Gerardo Vega.

Sudlersville, Md.—Charles L. Joslin.

Beatrice, Ala.—Clarke J. Stallworth.

Annapolis, Md.—Roger V. Parlett.

Laurel, Del.—William T. Chipman.

Windsor Locks, Conn.—Daniel H. Lawler.

Ansonia, Conn.—Edward H. J. Hennessey.

Bayview Hospital—John A. Skladowsky and Henry Diebel, resident physicians, insane department; R. Bruce Patrick, resident surgeon; E. A. Sherrill and George C. Battle, tuberculosis department.

Municipal Tuberculosis Hospital—W. Howard Yeager, chief resident physician.

Homeopathic Hospital—James A. Duggan, resident physician.

Marine Hospital—John C. Stansbury.

Presbyterian Eye, Ear and Throat Hospital—Edwin V. Whitaker.

We are asked to publish the following report of the receipts and expenses of the smoker given by the Adjunct Faculty to the graduating class of 1912:

Received from members of the Faculty..\$100 00

Disbursed:

To caterer.....\$71 40

Musical..... 12 00

Cigars, postage and incidentals.. 16 60

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Total.....\$100 00

The engagement is announced of Dr. James Hugh Bay, class of 1908, of Havre de Grace, Md., to Miss Mary Barton Saulsbury, University Hospital Training School for Nurses, class of 1909, of Baltimore, Md. Miss Saulsbury is a daughter of the late Dr. and Mrs. Thomas Bascom Saulsbury, of the Eastern Shore, and a sister of Mrs. William G. Pugh of Govanstown, Md. Dr. Bay is a son of Mr. and Mrs. Thomas A. Bay, Jarrettsville, Harford county, Maryland. The marriage will take place in the early fall.

Dr. Charles Alfred Goettling, Jr., class of 1910, is located at Denmore Park, Baltimore, Md.

Dr. William Douglas James, class of 1881, is located at East Brady, Pa.

Dr. Ernest L. Griffith, class of 1907, is located at 311½ 10th street, Huntington, W. Va.

Dr. Charles O'Donovan, class of 1881, received the degree *honoris causa* of LL.D. from Loyola College.

Dr. Archibald A. Chisolm, class of 1897, is the only alumnus located in Newfoundland. He is at Manuels, Harbor Main, Newfoundland.

Dr. Randolph Winslow and his daughter, Miss Eliza Winslow, sailed for Panama July 13.

The new internes at the University Hospital assumed their duties July 1.

So far as we are able to trace, there are but two alumni of the University located in Idaho. They are Dr. Joshua T. Price, class of 1868, Ilo, Lewis county; Dr. William M. Mitchell, class of 1905, Weiser, Washington county.

The Alumni Athletic Association has elected the following officers for the ensuing year:

President—Dr. Nathan Winslow, class of 1901.

Vice-President—Dr. Charles E. McCormick (Pharmaceutical Department).

Secretary—Dr. George M. Settle (Adjunct Faculty).

Treasurer—Dr. Robert L. Mitchell, class of 1905.

Board of Directors—Medical: Dr. I. J. Spear,

class of 1900; Dr. Robert P. Bay, class of 1905. Law: Mr. Cyril Hansell, Mr. James W. Bowers. Pharmaceutical: Dr. Daniel Base, Dr. Charles E. McCormick. Dental: Dr. B. M. Hopkinson, class of 1885 (Medical School); Dr. Clyde V. Matthews.

Manager Football Team—E. Holt Stevens, 823 North Fulton avenue.

Manager Basketball Team—H. H. Warner, 1009 Madison avenue.

Advisors to Teams—Football: Robert L. Mitchell (1905), R. G. Willse (1909), Frederick H. Vinup (1909). Baseball: W. H. Smith (1900), R. G. Willse (1909), Robert P. Bay (1905). Basketball: H. M. Robinson (1909), Homer U. Todd (1908), G. M. Settle (Adjunct Faculty).

Dr. Ernest Zueblin of Pittsburgh was a recent visitor to the University Hospital.

The following alumni were present at the banquet of the Alumni Association of the University of Maryland School of Medicine at the Caswell June 1, 1912: Drs. Wm. H. Pearce, Henry H. Weinberger, John I. Pennington, H. J. Hill, Randolph Winslow, J. R. Winslow, Leonard J. Turlington, Wm. E. Wiegand, A. Trego Shertzer, John W. Linthicum, H. Louis Naylor, E. M. Reid, A. D. McConachie, W. R. Eareckson, Geo. A. Fleming, H. C. Silver, W. S. Love, S. R. Waters, C. R. Winterson, V. L. Norwood, H. C. Houck, Wm. J. Coleman, A. L. Kirk, James H. Wilson, H. C. Davis, Joseph Gichner, J. Tyler Smith, John Houff, B. M. Hopkinson, C. Urban Smith, W. A. B. Sellman, Nathan Winslow, G. Lane Taneyhill, Chas. E. Sadtler, S. Demarco, Howard Kahn, Eugene F. Cordell, H. E. Zepp, H. H. Biedler, A. Carroll, W. F. Sowers, H. J. Maldeis, H. A. Naylor, James H. Jarrett, H. M. Robinson, Geo. H. Stewart, Joseph T. Smith, P. S. Fuld, J. H. Rehberger, F. R. Winslow, W. B. Kirk, Louis B. Henkel, Jr., G. Carroll Lockard, James T. King, M. C. Freilinger, E. H. Kloman, James M. Craig-hill, John H. Robinson, Robert P. Bay, Hiram Woods, Edw. M. Wise, Geo. S. M. Kieffer.

Rt. Rev. Luther B. Wilson, M.D., class of 1877, formerly a bishop in the Methodist Episcopal Church in Philadelphia, has been transferred to New York city. His headquarters will be 150 Fifth avenue.

Col. Louis M. Maus, U. S. A., class of 1874, and Capt. Perry L. Boyer, U. S. A., class of 1899, are located at Chicago.

Rev. Lynn Harold Hough, in speaking at the alumni banquet of the Medical School at the Caswell, June 1, said in part:

"One way in which to measure a man \* \* \* is by his physical vigor and efficiency. I am not forgetting that a great deal of the world's work had been done by her invalids. But, on the whole, the man physically fit has the truest outlook and the best opportunity. The man who is in the right bodily condition, other things being equal, will run the farthest and think the most clearly. Your profession stands for keeping people physically at their best. When the physician's millennium comes we will not send for doctors simply when we are sick; we will have them examine us periodically to keep us well.

"The second method by which you can measure a man is his strength of mind. It is the temptation of a man in any profession to become engrossed in the routine of his daily work and to let the advance guard of the profession sweep by him. But the man who measures up to the standards of his calling will read the great journals of his profession. He will know what the men who are its leaders are about. He will follow the story of what experimenters in laboratories across the ocean are doing. He will be a constant student of the literature of his line of work. This is to justify that fine old phrase which called the practice of medicine a learned profession. And in all this the power of a man's mind is enlarged, the grasp of his intellect is increased, and the instruments of his thought become more sharp and effective. So using his mind, he approximates the standard in respect of this way of measuring a man.

"Another test of a man is the power of his personality. Here are two men. One knows as much as the other. But one has a vivid, magnetic personality. He makes himself felt by the sheer force of personal vitality. He is the man who wins. You may feel very scornful about the Emmanuel movement, and you have a right to do it. But there is this much truth in the movement: A man who has a hearty, vital, vigorous personality adds an intangible but very valuable something to the power of the medicine he prescribes. The contagion of a life full of wholesomeness and health is of real value in the sickroom. The phy-

sician who has a potent, commanding personality adds very much to his other powers.

"The last standard I want to suggest for the measure of a man is reverence. You can tell a great deal about a man by what he reveres and how much he reveres it. Dr. Oliver Wendell Holmes, that brilliant and genial physician and poet, once said, 'There is a little plant called reverence in my soul's garden which I like to have watered about once a week.' The only thing the matter with this remark is that if the plant is to be kept alive it really needs water more than once a week.

"There is a type of reverence which is based on ignorance. It knows little of the bad of life. It knows little of the hard and brutal facts of the world. It has a childish, innocent reverence.

"There is another kind of reverence more impressive and more commanding. Here is a man who has looked life full in the eye. He has been struck down once and again by hard and disillusioning facts. He knows the worst of life, and heavy lines of experience and struggle have come on his face. It is the face of a warrior, a veteran in life's fight. But his eyes still gleam with noble reverence. Although he knows the world, he has not become bitter, he has not become a cynic. He is a man of noble confidence, though again and again he has faced the worst of life.

"No group of men have a better opportunity to develop this virile reverence than the men who follow the medical profession. I feel like congratulating you on your profession and on the contribution you can make to the life and health of the world."

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Dr. Page Edmunds, class of 1898, was elected vice-president of the Baltimore & Ohio Association of Railway Surgeons at its twenty-second annual meeting held in Philadelphia June 1, 1912. Dr. Edmunds read a paper on "Supra-Pubic Prostatectomy."

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Dr. S. W. Hammond, class of 1905, is located at 123 West King street, Martinsburg, W. Va.

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Dr. Clifton Norwood DeVilbiss, class of 1910, formerly a resident in the University Hospital, is located at Laytonsville, Md.

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Dr. C. L. Jennings, class of 1906, is located at 332 W. Monroe street, Jacksonville, Fla.

Dr. Joseph Connor Joyce, class of 1908, is located at Arnold, Anne Arundel county, Maryland.

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As far as known, all of the members of the class of 1912, University Hospital Training School for Nurses, have taken up private nursing.

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Dr. Alexander C. Abbott, class of 1884, of Philadelphia, Pa., and Dr. John S. Fulton, class of 1881, of Washington, D. C., are members of the Committee of One Hundred on National Health of the American Association for the Advancement of Science.

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Dr. T. Morris Chaney, Jr., class of 1906, of Old Fort, N. C., was a recent visitor to Baltimore.

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Dr. William Cuthbert Lyon, class of 1907, who is spending his honeymoon abroad, writes us from Berlin, June 26, having previously visited Paris and Venice.

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Dr. Henry C. Ohle, class of 1886, of 1205 W. Fayette street, who lost his eyesight through an infection received from pricking his finger while operating two and a half years ago, is considerably better, and believes that he will be able to recognize his friends within six months, and to resume his practice. Dr. Ohle has been operated upon six times, and after 16 months of blindness he is now able to see indistinctly, as through a maze. We sincerely hope that the present outlook may be verified, and that Dr. Ohle may walk among us again, seeing clearly.

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Miss Mary E. Sullivan, class of 1911, University Hospital Training School for Nurses, is assistant superintendent of the University Hospital.

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Dr. Z. C. Myers, class of 1881, of 278 W. Market street, York, Pa., was operated on recently at the University Hospital. He is reported to be doing nicely.

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Surgeon George Young, U. S. P. H. and M. H. S., class of 1887, is stationed in Chicago at 1441 Clarendon avenue. He is also City Health Commissioner.

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Dr. Robert P. Bay, class of 1905, read a paper before the meeting of the Maryland State Dental

Society, his title being "Early Diagnosis of Oral Tumors."

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Dr. Charles W. Mitchell, class of 1881, was a classmate of Governor Woodrow Wilson, and was overjoyed when told of his nomination. Dr. Mitchell said:

"This has been a great day for me, but really, you embarrass me when you ask me to give you an interview over the outcome of the fight for the nomination." But when reminded of the fact that he was a classmate of the nominee he began by paying a glowing tribute to Wilson.

"I have been intimately acquainted with Governor Wilson for the past 35 years, ever since we were college boys together, and I am not at all surprised at his success, because he possesses every characteristic and trait that makes him what was apparent to all of us when at college.

"Yes, we graduated from Princeton in the same class—the class of 1879—and I might add, in passing, that another of our classmates has only recently been appointed by President Taft as a member of the Supreme Bench of the United States. He is Maklen Pitney."

Then turning to the political situation in general and the achievements of Governor Wilson, Dr. Mitchell said: "Politics in this country has come to the parting of the ways, and it is a question between the privileged classes and the people at large. I regard the selection of Governor Wilson as the logical move for the convention to have made. It is a splendid triumph for this distinguished gentleman, a moral picture and the downfall of the machine. Personally speaking, Governor Wilson is a man of wonderful intellectual achievements, absolute integrity, splendid courage and unselfish in his devotion to the interests of the whole people. I do not have the slightest doubt of his election, and he will make an excellent President. In the face of the nomination of Woodrow Wilson there is removed every possible need or reason for the organization of any third party, for he embodies every ideal to appeal to the people at large, and I have no doubt but that many Roosevelt followers will flock to him on election day."

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Miss Mary Louise Gephart, University Hospital Training School for Nurses, class of 1911,

has been appointed superintendent of the new Havre de Grace (Md.) Hospital.

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Dr. Herbert Seth Anderton, class of 1910, has passed the Board of Medical Examiners of the State of California.

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The following item is clipped from *The Star* of Wilmington, N. C. Dr. Bulluck is a graduate of the class of 1911:

"It is gathered from the State press that Dr. Ernest S. Bulluck, a conspicuously talented and successful young physician and surgeon of Wilmington, was the recipient of a really signal honor at the hands of the North Carolina Medical Society recently in session at Hendersonville. He was made vice-president of that august assembly at a much earlier time of life than the honor usually comes to the few who attain it. It is noteworthy that the society, composed as it is of the most eminent physicians and surgeons of the State, should show its marked appreciation of the young men of the profession. Its distinguished favor is to be highly prized, and its broadness certainly is manifest in its consideration of young men of mark.

"Young Dr. Bulluck read before the society a paper on "The Practical Application of Iodine in the Preparation of Patients for Operations," and it is observed that this production brought forth extensive discussion and approval on the part of many of the State's best-known surgeons.

"It will be gratifying to the young Wilmington doctor's host of friends to know this, and it certainly gives pleasure to *The Star* to favorably mention any of the rising generation who, by singleness of purpose and patient industry, are striving earnestly to attain mastership in the various paths of endeavor."

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## MARRIAGES

Dr. Roscoe Drake McMillan, class of 1910, was married to Miss Gertrude Anna Garrison, University Hospital Training School for Nurses, class of 1910, at the home of the bride, "Havendale," Burgess Store, Va., June 10, 1912. Mrs. McMillan is the daughter of Mr. and Mrs. Lewis Ellison Garrison.

The bride wore a gown of white princess satin trimmed with princess lace, and carried lilies of

the valley and roses. The maid of honor, Miss Genevieve McMillan, wore spangled chiffon over blue satin, and carried sweet peas and roses. The bridesmaids, Misses Louise Blundon, Raphael Skinner and Florence Edwards, wore gowns of crepe meteor. The best man was Mr. Kenneth Craig Denny of Red Springs, N. C., and the ushers Messrs. Herbert L. Garrison, J. M. McCallum and Howard Rice.

The house was decorated with daisies and ferns. The ceremony was performed by Rev. A. J. Reamy, in the presence of a large number of friends and relatives.

Dr. and Mrs. McMillan left immediately after the wedding for Washington, where they will spend a few days, afterwards motoring through North and South Carolina.

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Dr. Newton Webster Hershner, class of 1906, of Mechanicsburg, Pa., was married to Miss Wilna Anna Landis, also of Mechanicsburg, on Tuesday, June 18, 1912. The couple will be "at home" after August 1 at 213 West Main street, Mechanicsburg.

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Dr. Louis E. Langley, class of 1910, of 1129 Baldwin street, Williamsport, Pa., was married to Mrs. Nora L. Burke of Centerville, Md., at Baltimore, Saturday, June 29, 1912, at 10 A. M. Dr. Langley is 28 years of age, and was a very popular member of the class of 1910. His first wife, Mrs. Daisy E. Langley, died some years ago. Dr. Langley has a son, E. Surran Langley, five years of age.

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Dr. Harry Downman McCarty, class of 1905, of 613 Park avenue, Baltimore, was married to Miss Mary Maitland DuBois of Ruxton, Md., at Baltimore, June 24, 1912. Dr. McCarty is a member of the Adjunct Faculty of the University of Maryland, and is 30 years of age.

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Dr. John Shaw Gibson, class of 1905, of Gibson, N. C., was married to Miss Edna Iona Ebert, daughter of Mrs. Emma E. Ebert and the late John W. Ebert, on Tuesday, June 11, 1912, at the Second English Lutheran Church of Baltimore. Only the immediate relatives of the contracting parties were present. Dr. and Mrs. Gibson left for a sea trip to Boston, and will visit in New England and New York, returning to Gibson, N. C., August 1.

## CORRESPONDENCE

In Dr. Howard A. Kelly's *Cyclopedia of American Medical Biography*, the following statement is made with reference to the life of Dr. Horatio Gates Jameson. "His sons were all physicians, and died leaving no descendants." While the statement is absolutely correct, we fear that it may be misconstrued to mean that there are no lineal descendants of Dr. Jameson now living, which is incorrect, as the following communication from his grandson, Gen. Horatio Gates Jameson Gibson, U. S. A. (retired), shows:

1412 21st St. N. W., Wash., D. C., June 12.

*Editor Hospital Bulletin,*

*University of Maryland, Baltimore, Md.:*

In reply to your letter of June 10 asking information in regard to the descendants of my grandfather, Dr. Horatio Gates Jameson, I take great pleasure in giving you all the information that I have gathered in regard thereto in the last 30 years:

His sons, as you state, were all physicians, and died early, leaving no children. The last to linger on the scene was his namesake, who lived and practiced his profession at Mt. Washington, near Baltimore, for some years prior to his death in 1865. He married, but his only child died in infancy.

All Dr. Jameson's children passed away some years ago. Of their children the following survive: Catharine Rebecca Maze, Horatio Gates Jameson Gibson, George Fisher, Emily Shevell Alricks, Annie Helen Latimer, Robert Strettel Jones Fisher; and of the next generation there are living: Anna Margaret Hopkins, Horatio Gates Gibson Schissler, Robert John Schissler, Horatio Gates Jameson Gibson, Katharine Fisher White, Agnes Gibson Wallace, Henry Kendrick Gibson, Robert Fisher Gibson, Charlotte Packard Farquhar, John Jameson Gibson, Robert Barry Fisher, Catharine Fisher, Helen Fisher, Catharine Latimer Ross, Emily Latimer, Jannette Latimer, Robert Fisher Latimer, Catharine Fisher Marshall, Ellen Mason Young, Annie Marshall Cole. Of the next generation there are: Katharine Virginia Wylie, William Hopkins, James Herron Hopkins, Katharine Lisenard White, Walker Gibson White, Arthur Farquhar, Robert Gibson Farquhar, Charlotte Farquhar. The latest generation has: Andrew Wylie, Katharine Virginia Wylie, Margaret Wylie, Craig Wylie and the

children of Robert and John Gibson, as well as those of Robert Barry Fisher and Robert Fisher Latimer, of whom I have no knowledge. Robert Gibson married Hattie McKenney of Centerville, Md., and John Gibson married twice, and both have children.

My grandfather's eldest daughter, Cassandra Jameson, married Rev. William J. Gibson, and had several children, of whom only one survives—Catharine Rebecca Maze of Carroll, Ia.

My mother, Elizabeth Jameson, married Rev. John Gibson, and had several children. William, who became a commander in the navy, married, but had no children. He wrote and published "A Vision of Faery Land and Other Poems," "Poems of Many Years and Many Places," "Translation of the Poems of Goethe," reviewed and approved by Bayard Taylor, Paul Carus and other literati. Horatio Gates Jameson, now like his namesake in the Revolution, "a general in the army"; John, who became president judge of the 19th judicial district of Pennsylvania; Robert, who became a lawyer, and in 1861 joined the army of Sterling Price in Missouri, served in the battle of Carthage, and soon after was stricken with typhoid fever and died; William followed in 1887, and John in 1890. Margaretta Rebecca Mitchell married Hiram Schissler, and had several children—Katharine Chevelle, Anna Margaret, Horatio Gates and Robert John. Katharine married Frederick Jean Nelson, a lawyer of Frederick, Md., but had no children. Anna Margaret married James H. Hopkins of Pittsburgh, in Congress 1875-77 and 1883-85, and had several children—William, Katharine Virginia, James Herron. William is now a captain in the Marine Corps of the United States, and Katharine Hopkins married Horace Wylie, and had several children—Andrew, Katharine, Margaret and Craig. Margaretta Schissler died in 1879, and Katharine Nelson in 1889. My mother, Elizabeth Gibson, died in 1855. William Gibson married Mary Dulany Addison, but had no children. Horatio Gates Gibson married Harriett Leavenworth Atkinson, and had several children. Of these are living Horatio Gates, who adopted the profession of his grandfather and namesake, and is one of the physicians in charge of the New York State Hospital at Central Islip, Long Island, and is often consulted as an alienist. He married Elizabeth McGrann, but has no children. Catharine Fisher Gibson married Frank Hollis White, and had two children—Kath-

arine Lispenard and Walker Gibson. Agnes Gibson married George Weed Wallace, but has no children. Henry Kendrick Gibson married Gertrude Davis, but has no children. John Gibson of York married Helen Packard, and had several children—Robert Fisher, who is the rector of the Episcopal Church in Williamsport, Pa., ordained after serving two terms as Mayor of York. Charlotte Packard, who married Frank Farquhar, and has several children—Arthur, Robert Gibson and Charlotte. John Gibson married twice, and has two children. He is employed in the Westinghouse electrical business in Philadelphia.

Catharine Jameson married Robert Jones Fisher in Cincinnati in 1836 whilst her father was president of the Ohio Medical College, and lived the rest of her days in York, where her husband was president judge for 30 years. She had several children—George, Catharine, Emily Shevell, Annie Helen and Robert Jones. George Fisher married Mary Barry, and had several children—Robert Barry, Catharine and Helen. They reside in Baltimore. Catharine (York) married James M. Marshall, later a colonel in the army, and had several children—Catharine Fisher, Ellen Mason, Annie. Ellen married Dr. George Bright Young of the U. S. Marine Hospital Service, and has several children. Annie married Capt. James A. Cole of the army, and has children. Emily Shevell married Levi B. Alricks of Harrisburg, but had no children. Annie Helen married James W. Latimer, later president judge in York, an office filled by three members of the family, and had four children—Robert Fisher, Catharine, Janette and Emily. Catharine Latimer married Brooks Ross of Delaware, and has two children. Robert Jones Fisher married twice—Harriet Tyler of Brattleboro, Vt., and Louise Martin of Washington—but has no children. He was Assistant Commissioner of Patents under President Harrison, and is now the attorney for the Eastern Railroad Association, and resides in Washington.

My grandfather's second wife had a son by her first husband—Jesse F. Ely. He is a prominent business man in Baltimore, and as I saw but little of my grandfather after 1840, you may be able to obtain some information from him which my sojourn in York, at West Point, Mexico and California denied me the opportunity of obtaining.

Very truly yours,

H. G. GIBSON,  
Brigadier-General, U. S. A., Retired.



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## AMEBIC DYSENTERY.\*

By ROSCOE McMILLAN, M. D., (1910)  
Red Springs, N. C.

Historically, dysentery is among the oldest of described diseases, some symptoms and treatment being known as far back as 1600 B. C.

Hippocrates was the first to describe it as an infection. In regard to the geographical distribution, Ayrs has commented on the fact that "of dysentery it may be said where man is found there will some of its forms appear."

The term dysentery implies a symptom rather than a single pathologic entity, but the recent words of Shiga, Flexner and others render the etiologic classification clearer. The old clinical distinction of endemic, epidemic and sporadic dysentery hold good, as well as those of acute and chronic, and the pathologic varieties—catarrhal, ulcerative and diphtheretic. But the etiologic classification is perhaps the best.

*First*—The chemical, as from irritating foods and metals, such as copper, arsenic, mercury, lead, etc.

*Second*—The bacterial or bacillary, as the Shiga, Flexner and B. Pyocyaneus.

*Third*—Protozoal, or the amebic type.

Lambl, in 1859, was the first one to offer the suggestion of a specific cause for dysentery. Koch, however, three years before this had demonstrated ameba from sections in an ulcerated bowel, showing a relationship between the parasite and the intestinal lesion. In this country the first ameba were discovered by Osler in 1890, and shortly after confirmation came from Stengel and from various sources, and now the disease has been found to exist scattered over many sections of this country and in all parts of the world, but it is essentially a tropical or semi-tropical disease,

and prevails more extensively in warm climates and in connection with poorly-drained soil. In certain sections of the South, right here in our own neighborhood, conditions are almost ideal for the prevalence of this infection, so this subject should be one of lively interest. But, unfortunately, it is scarcely regarded by the profession in a light at all befitting its high importance. It is a very regrettable fact that by most physicians in private practice, and even in the best hospitals in the Southern sections of the United States, it is not recognized as a distinct disease.

The records of most of them—90 per cent. I venture to say—classify amebic dysentery under the general term of "chronic dysentery."

Amebic dysentery is a colitis, very rarely an ilio-colitis, caused by the ameba dysenteriae of Councilman and Loeffler. It is considered by most authorities different from the ameba found in the stools of healthy man, to which alone the name ameba coli is given. It would be very interesting, did time permit, to discuss the various views advanced by pathologists as to the real etiologic factor in these cases.

The parasite is water-borne, or it may be conveyed by contaminated soil to the mouth by dirty hands, or from eating green vegetables grown in sewage polluted ground. The parasite is from 15 to 20 m. diameter, having an outer zone (ectosarc) which is clear, and an inner zone (endosarc) which is granular. It contains a nucleus, several vacuoles and perhaps some foreign bodies, as bacteria, blood cells, etc. Its movement is characteristic. It moves by putting forth protrusions of the ectosarc in various directions, for a time not changing its location; then presently the endosarc gushes forth into an unusually long protrusion, and the ameba move across the slide.

The essential feature of the disease is always an ulceration. Inflammation of mucosa is more or less general. The submucous coat becomes edematous; there is infiltration, and this raises

\*Read at meeting of N. C. State Medical Society, June 18, 1912, Hendersonville, N. C.

the mucous membrane in round patches, necrosis sets in and the membrane sloughs. The ulcers formed are either round, oval or irregular. They extend to various depths, so sometimes perforation of gut becomes a complication. The ameba are also found in the tissue, around the ulcers, in the lymph spaces and in small blood vessels. Abscess of the liver is one of the most serious complications, and this probably takes place through the portal vessels.

The characteristic lesions of the disease are always found in the large bowel, and the generally accepted belief is that the primary site of infection is in the cecum, whence the infection is carried by natural forces throughout the colon and rectum. It is claimed by some that the distal portion of the ileum is sometimes involved, but this is denied by the best authorities.

The symptoms do not differ much from those due to ulceration of intestine from other causes. Loose stools, discharges of mucus, pus and blood, tenesmus, abdominal distension, loss of appetite, strength and flesh, and a progressive anemia. But these are not always constant or clearly defined.

The disease is essentially a chronic one, and occasionally during its course there are times when the patient thinks he is well, or great deal better, as most all of the symptoms have subsided, going even so far that patient may suffer somewhat from constipation. The parasites are, so to speak, under cover, and soon break out under certain conditions favoring a renewed activity. When the diarrhea occurs it does not follow any set rule, as great deal depends on the location of the ulcers. If they are low down in the rectum, there are frequent evacuations, accompanied by marked tenesmus. If the lesions are in sigmoid or above it, the movements may not exceed two or three per day. Mucus sometimes is absent, but blood or blood-streaked mucus is fairly constant.

As I have said, the symptoms are not always constant or clearly defined, so a bedside diagnosis should not be relied upon entirely. By making a careful examination per rectum and by using some of the simple methods of examination, the diagnosis should present no difficulties. The ulcers are characteristic. They show a tendency to extend in direction of circular muscle fibers of the gut, and they are covered with white or dull gray pellicles, the removal of which leaves

a raw bleeding area. The microscope should be used, the slide being warmed to body temperature and specimen carefully handled. The ulcer should be scraped and should be free from mucus and fecal matter, the cover glass firmly pressed down on slide. When present, the ameba, with their characteristic movement, is sufficient for diagnosis.

Leucocytosis is always present, and is in proportion to the severity of the disease.

The diagnosis and treatment is of utmost importance. The utter hopelessness of a great number of cases is due to their being allowed to drag on until they yield to no treatment at all. The actual sources of infection are numerous, so prophylaxis becomes a complicated problem and its scope beyond the prescribed limits of this article, but I do want to emphasize hygienic and sanitary measures. The first in regard to the patient. This includes fresh air, sunshine and cheerful surroundings. In some cases change of climate may be helpful, especially through its effect on the general health. The sanitary measures in regard to those in close proximity to patient. Instruct the nurse or attendant upon the absolute necessity of destroying all discharges from the bowel and cleansing hands after waiting on patient. The infectious agent is probably in the main water-borne, and the danger of contaminating the water supply should be carefully explained.

*Second*—Rest is always of great importance.

*Third*—Diet. For a few days it is well to restrict him to liquids. Predigested foods, peptonized milk, soft toast and soft-boiled eggs are sometimes well borne.

*Fourth*—Medication by mouth. I don't believe there is any known drug administered by the mouth which will retain sufficient potency after going through some 20-odd feet of intestine to have any direct influence on the ameba. I am fully aware that ipecac coated with salol, given in large doses, is lauded by many whose opinion is entitled to all respect, but, speaking generally, the administration of medicine by the mouth should be resorted to only in the presence of clear-cut indications. The routine administration of any of the so-called specifics is strongly condemned, but I do believe that in the beginning and from time to time a mild mercurial purge should be given.

*Fifth*—Local Treatment. Irrigations per rec-

tum with cleansing antiseptic solutions constitute, in my opinion, the main dependence in a large number of cases. A wide diversity of opinion exists even here as to the most effective solution to use, but solutions of quinine are most widely approved, beginning at 1 to 5000 of a body-warm solution, used twice a day for a few days and gradually increasing to 1 to 1000. At least half a gallon should be introduced before any of it is allowed to return. Later, as patient improves, every other day or twice a week should be often enough. This should be kept up for some weeks after patient seems cured, and certainly until repeated examinations fail to reveal any ameba. The success of this treatment depends on certain details in carrying out the irrigations, namely, marked elevation of hips, insertion of small rectal tube 3 or 4 feet into colon and retaining the fluid for at least 15 or 20 minutes. Other solutions, as boric acid, common salt, hydrastis and silver nitrate, have been used and recommended by some.

When the rectum is very irritable, a preliminary injection of some anodyne solution, as cocaine or opium, will be required.

But in spite of all I have said, some cases do not yield to rectal lavage of any of the solutions I have named, no matter how thoroughly used, and in these cases I think surgery offers a very promising field. The operation of choice is appendicostomy, in which the caliber of the appendix is used as a means for successful medication of the large bowel. If for any reason the appendix is absent or has suffered disease, the cecum is the next resort. The solutions for use here are the same as used per rectum. Understand, I do not claim this as a curative procedure, but it does offer in certain cases the only possible means of gaining access to the ulcers when they are situated very high up. I will not go into the technique of operation, but if it is performed under proper conditions by competent operators, it should give no larger mortality than operation for appendicitis. The disease itself is by no means free from danger to life, as one single complication, such as amebic abscess of liver, causes a far greater mortality rate than that of appendicostomy.

Dr. Albert Hynson Carroll, class of 1907, is at Woods Hole, Mass., as the guest of Dr. Leo F. White, professor of chemistry at Clark University.

## REPORT OF CASE.

By CHARLES WESLEY ROBERTS, M. D., (1906)  
of Douglas, Ga.

*Mr. President and Gentlemen of the  
Eleventh District Medical Society:*

With your kind permission I desire to invite your attention to the following case report, feeling that it is one of sufficient importance and interest to command your careful consideration during the few moments allotted to me on the program. I have given the history and after-treatment somewhat in detail, and if it proves tiresome to you to the extent of boring, I shall seek to reinstate myself in your good-will by alluding to the fact that it is the lack of important detail in our current literature and textbooks that makes us search for help in vain, authors evidently looking upon minute detail as of trifling significance:

W. D. N.; age 26; born in South Carolina; family history negative as affects this report.

*Personal History.*—Had typhoid fever when 16 years of age, lasting some two weeks, from which he made complete recovery. Soon after attack he weighed more than ever before and was in perfect health.

Present trouble began five years ago as follows: After taking food patient would have formation of gas on stomach, and some two or three hours after meals would have extreme colicky pain in epigastric region of such severity as to require something for relief. Patient says he would take some soda or drink water or take some food and the pain would be relieved. This pain was accompanied by tenderness in the epigastrium, nausea, but no vomiting. Pain did not come after every meal, but would usually have at least one attack during each day. He rarely ever had attacks at night, and does not remember to have had an attack on getting up before breakfast.

Patient says that he consulted several physicians for this "stomach trouble," and when he took medicine and was careful about his diet he would get better, so that there would be intervals of weeks or months when he was practically free from pain. After some three years of suffering of the above type patient says he began to have pain radiate through to back about the region of the eleventh or twelfth dorsal vertebrae and

around into the left axillary region. Attacks were more severe and produced such nausea as to cause vomiting, which would usually relieve the attack. This vomiting was productive of only stomach contents making his teeth very sharp. Attacks came with the same regularity, but usually about two or three hours after a meal. After about a year of this type of suffering, during which time, under treatment and diet, he would get better, to have a return of symptoms after intervals of partial relief, patient says all symptoms became exaggerated, pain was more constant and of such severity as to cause him to double up in bed, and would radiate all over upper abdomen, produced vomiting more often, and his general health began to fail. His condition grew gradually worse until patient was confined to bed, and for some three months previous to his admittance to hospital he vomited every day, after nearly every meal, and became emaciated, losing some 25 or 30 pounds. On one occasion patient vomited a large quantity of clear blood, and says that this was accompanied by extreme weakness. No history of dark or tarry stools.

On admittance to hospital patient presented the appearance of extreme emaciation, was very sallow, with hollow cheeks and eyes, very pale conjunctivae, and was constantly eructing gas. Physical examination revealed nothing abnormal about chest, kidneys, genitals or abdomen save about epigastric region. On distention of stomach with a seidlitz powder it was found greatly enlarged, reaching below umbilicus an inch or more. Nothing could be palpated about the pylorus, but patient complained of tenderness about this region. Gall-bladder area was negative. The first day in hospital patient was given full diet, and he took all that was given him because he was extremely hungry. There was no pain or vomiting until the second day, when attack came suddenly, causing the vomiting of all solid food taken the day before, along with about one-half gallon of sour fluid mixed with mucus and an occasional streak of blood. This vomited matter when left in a glass vessel for an hour showed the three-layer formation seen in atonic dilatation of the stomach or retention of food from any cause—*i. e.*, solid food at bottom, a clear area of liquid and top layer of mucus. Chemical examination showed free hydrochloric acid and no lactic acid. Microscopic examination re-

vealed an abundance of yeast cells. After vomiting the patient was relieved and ready for more food.

A Saltzer-Ewald test meal gave the following findings: Free hydrochloric acid, 30; total acidity, 50; no lactic acid. Some three days later a second test meal was examined and gave about the same findings. Urine examination showed no albumen, sugar or bile. Hemoglobin was between 50 and 60. Patient weighed 115 pounds.

Now, the history in this case and findings after admittance to hospital pointed very definitely to pyloric obstruction, and it was fair to presume that this obstruction came from a healed or partially healed gastric ulcer. The sallow appearance of the patient led us to suspect gall-bladder involvement, but careful examination showed no evidence of such complication, and on further questioning of the patient we learned that this was a family characteristic, exaggerated in this case by the marked anemia.

To sum up the history, we have the following: A slowly-developing stomach trouble, with intervals of relief, followed by another onset, and finally vomiting, causing temporary relief, then vomiting of blood—a chain of symptoms pointing pretty definitely to gastric ulcer. The findings after admittance to hospital showed positively that the patient had pyloric obstruction, and the test meals led us to exclude from the case the question of cancer as a cause. The finding of blood-streaked mucus and a constant, rather high free hydrochloric acid content argued in favor of an active ulcer.

Exploratory laparotomy was advised and readily accepted. Under ether the upper abdomen was opened through the right rectus, the gall-bladder palpated and found free from adhesions, compressible and without stones. Ducts negative. Head of pancreas enlarged, but not woody-hard, rather giving the sensation of an edematous condition. On retracting the abdominal walls a large scarlike area involving the pyloric end of the stomach came into view. The entire ring of the pylorus was involved in a thick, rather hard mass, not permitting any penetration of the pyloric opening. No active ulcer condition as evidenced by a crater-like feel in any part of this scarlike area could be made out, but the mass seemed to be simply an edematous infiltration of the pylorus, with a very evident scar showing in the wall and extending well around the stomach

near the pyloric end. Several small glands were noted about the mass and in the meso-colon of the transverse colon.

Posterior gastro-enterostomy was decided upon as an operative measure for relief and rapidly performed by the suture method without clamps, making an anastomotic opening of some two and one-half inches between the posterior wall of the stomach and the first part of the jejunum.

Patient was put to bed in the Fowler sitting posture, which was maintained throughout the convalescent period. Normal saline proctoclysis begun at once and kept up at intervals for three days. Soon after being returned to bed patient vomited small quantity of dark fluid. This was the last vomiting, there being no more while in hospital, nor any since being discharged.

The convalescent period was absolutely uneventful, patient being allowed warm water, one ounce at a time, the first night after operation, the quantity subsequently gradually increased. Liquid nourishment was given the second day and semi-solid diet the fifth day. At the end of the first week after operation patient was taking a fairly full diet. On the morning of the third day, following a dose of castor oil the night before, patient had a good bowel movement, containing considerable dark, disorganized blood—a typical tarry stool. There were no abnormal stools after this. Wound healed primarily, and the patient was allowed out of bed on the eleventh day and was discharged on the eighteenth day following operation.

There was absolute and immediate relief of all symptoms, and the result has been so gratifying that I have had Mr. Norton come down with me that you might see him and ask any questions that may interest you. It is now some four months since the operation, and patient has remained well and free from symptoms and has gained about 40 pounds.

The announcement is made that Dr. Eugene Bascom Wright, class of 1909, will, on September 1, succeed Dr. Chadbourne Andrews as superintendent of the Hebrew Hospital, a position held for several years by Dr. Charles Bagley, Jr., class of 1904. Dr. Wright was for several years resident physician at the Church Home and Infirmary, and on September 2, 1911, succeeded Dr. Don Peters as superintendent.

## A CASE OF SIX MONTHS' MISCARRIAGE INDUCED BY MEASLES AND COMPLICATED BY TUBERCULOSIS.

*Written and Attended by* CHAS. W. RAUSCHENBACH, Senior Student, Under the Guidance of E. H. KLOMAN, PH. G., M. D., Associate in Abstract.

This case is brought to the attention of the readers of the HOSPITAL BULLETIN because of the rarity with which such a condition, as here presented, is seen.

The probable cause of abortions in pregnant women who are suffering with measles is an acute infectious deciduitis. Some writers believe that the uterine contractions are caused by the irritation of the exanthem as it occurs in the mucous membrane of the uterus, this disturbance being analogous to the fever, cough, photophobia, coryza, bronchitis and vesical tenesmus which so frequently complicate the eruptive fevers. Therefore we see no reason why the same explanation does not hold good for abortions occurring in any of the eruptive fevers, as is given for the above mentioned complications. The pathological changes are marked by small or large inflammatory changes in the decidua, and within these patches many different varieties of bacteria have been found, but no specific one. Measles will terminate the vast majority of pregnancies, and the eruption will occasionally be noticed on the foetus. Kaltz had eleven cases of measles complicating pregnancy and nine of these aborted. The usual percentage to abort in these cases is given as at about 75. The chief dangers in the puerperium in these cases are hemorrhage, pneumonia, occasionally uterine sepsis, and the double danger of the lighting up of some old tubercular area by the combined drain of pregnancy and measles.

The patient is a primiparous colored girl, of good physique and stature, and 19 years of age. Her menses first appeared at the age of 13, had been regular, lasting four to five days, and unassociated with pain.

Her family history is absolutely negative as to the bearing on this case. Her past history is negative, except that she has had all the symptoms of a pulmonary tuberculosis for the past

five months, viz., night sweats, coughs and flushes of heat.

Her general physique is good and her musculature firm and well developed. She shows no signs of any other disease, but her pelvis is slightly generally contracted. Her pelvic measurements are as follows:

Distancia spinarum.....	23 cm.
Distancia cristarum.....	25 cm.
Intertrochanteric .....	29 cm.
Baudeloque.....	18 cm.

The present pregnancy was associated with the usual morning nausea and vomiting; but unassociated with any of the special symptoms or complications, except that one week prior to the miscarriage she had a severe vomiting spell.

Upon our arrival at the house we found the patient in a talking delirium, lying upon a broken-down bed in a miserable dirty back room, just under the roof, when the sun was shining with the temperature of a boiler-room. In one corner of the room, lying upon a coal stove and covered with flies, lay the baby, placenta, cord and membranes all attached.

We subsequently learned that the child had been delivered 18 hours previous to our arrival, by a colored midwife. As far as could be ascertained, the delivery was normal and uncomplicated. As previously stated, the woman was found in a delirious state, with a temperature of 103.5° F., and her measles rash well out and covering her entire body. As the patient's skin was of a very dusky hue they appeared as small black papules, hard in consistency and giving a grating sensation to the hand when passed over them. She had a pulse rate of 135 beats per minute, which was of fairly good tension, small volume, and well sustained. Her respirations were 25 per minute. She also had a very severe, dry, hacking cough, and had lain in the same muttering delirium as above described the entire previous night; her lochia was scanty, of the characteristic normal fleshy odor, red in color, and contained no clots, membranes nor shreds. Her other genital and excretory organs were normal and functioning. As we considered the patient in too serious a condition we deferred further examination.

We immediately administered an ice sponge, to which she reacted fairly well, coming out of her delirium, and for the first time that day, taking an interest in her surroundings. We then

gave instructions that she be given an ice sponge every two hours until our next visit unless she went to sleep, when she was not to be disturbed. We also made them take out the windows in the room to afford better ventilation.

The following morning we found that she was still comatose and obtuse, but her delirium had left her. She had spent a very restless night, but had gotten a little sleep. Her lochia had now become very scant and possessed a very foetid odor. We now directed that she continue to be sponged and be given a glass of water every two hours while awake.

Upon seeing the patient in the evening of the same day she had responded very nicely to our plan of treatment her temperature being 99.2° F., a drop of 4° F.; her pulse 110, a drop of 25 beats, and her respirations remaining at 25 per minute. Her greatest response, however, showed itself in her mentality, though still being a little drowsy; she had not had any further delirium, was aware of her surroundings and answered questions somewhat intelligently. Her measles rash was now most prominent on her lower extremities and, in fact, that on her face was disappearing. She had slept some during the day and had eaten, for the first time in 48 hours, two pieces of toast, a soft boiled egg, and a glass of iced tea. She had, however, developed a most annoying complicating bronchitis and laryngitis, which greatly added to the distress. This complication also aggravated her cough and the continuous coughing caused her to have a constant throbbing headache. The sponges were now ordered discontinued.

The next day, i. e., the third day of our treatment, we found that she had not slept any the previous night, her bronchitis had become so severe that she could not talk above a whisper, and she had a remittance of temperature to 102.5° F. Just what caused this recrudescence of temperature could not be ascertained. We now administered the following prescription to alleviate her cough, bronchitis and laryngitis:

Syrupi Senegae.....	
Syrupi Squillae.....	aa dr. ii
Ammonii Chloridi.....	dr. i
Elixiri Terpini Hydratis et	
Herioni.....	oz. i
Syrupi Strobi Pini Com-	
positi—q. s.....	oz. ii

She was given a drachm of the above every

two hours. This seemed to lessen her cough, which became moist, and cleared up her bronchitis. She was still kept on a light diet, consisting of soft boiled eggs, mutton broth, toast, and tea, either hot or iced. Just what caused her laryngitis was not quite apparent to us, but it was our opinion that it was tubercular induced by the measles lighting up her tuberculosis.

On the fifth day we deemed that the patient's condition warranted making a physical examination of her chest. Her chest, on inspection, was well developed, and showed no evidences of rachitis or emphysema. The skin covering it was loose and inelastic, and the respirations apparently equal on both sides, but increased. On palpation tactile fremitus was found to be absent, but the respirations in the upper left lobe were somewhat retarded. Upon percussion we found almost flatness in the upper left lobe and slightly impaired resonance in the bases of both lungs posteriorly, apparently due to hypostasis. On auscultation harsh tubular-like breathing was heard over the left apex, i. e., the breathing was loud in character, expiration harsher and longer in duration than inspiration; and vocal fremitus increased over the same area. Numerous moist sibilant rales were heard throughout the chest both on inspiration and expiration, and some of a musical twang, in all probability due to the bronchitis. Pectoriloquy was negative. We next had a sputum examination made and the tubercular bacillus was found to be present.

The patient subsequently made fairly good progress towards recovery. Her temperature slowly descended, but she still had her nightly remissions. Her pulse and respiratory rates have also gradually descended until at present they are nearly normal.

At the time of discharge, which was ten days after beginning treatment, the patient was able to get out of bed and sit around. Her breasts were perfectly normal, in fact they never had developed milk; her uterus well involuted, in the pelvis, and occupying its normal position; her lochia of a serous character, moderate in amount, and normal odor; and all her excretory organs functioning. Finally she was advised to go to the Tubercular Department of Bay View Asylum by Dr. Lee, which advice, however, was not accepted.

This report is incomplete without the description of her present physical condition, which un-

doubtedly would show some interesting sequelae; but as all know the members of her race bear ever in mind such instinctive fear of hospitals, that with all the persuasive powers we could command we were unable to get her to consent to permit an examination at hospital.

Child.—The child was a female, well formed for eight months. It weighed four pounds and an ounce, and was 33 cm. long. There were no blemishes upon its body, nor any other evidences which would tend to show that the child had contracted rubella from its parent. The cord, placenta and membranes were perfectly normal, but small, and presented no anomalies.

Resume.—There can be no doubt that the patient had pulmonary tuberculosis, as the bacilli were found in the sputum, nor any doubt that she did not have measles (but some other exanthematous disease simulating measles) as there were six other children in the house afflicted with typical cases of measles. As to just what caused the miscarriage is all a matter of probability, the most likely cause being measles. Our whole treatment consisted of but simple palliative measures which aided nature to combat the morbid condition and aid in the elimination of the deleterious materials formed by the disease.

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Prof. Randolph Winslow received the following letter from Dr. Gerardo Vega, class of 1912, shortly before leaving for his Panama trip:

*"Dear Professor:*

"This is just to tell you that I have passed successfully the State Board, which was quite strong. I never thought it was so strong. I was called by the examiners, five in number, and was congratulated upon my good preparation, which makes me feel proud of my dear old Alma Mater.

"About the negro uprising, I will tell you everything is quiet and safe, so if you will kindly tell me when you expect to pass around here or Santiago, I would like to see you. Please remember me to all my dear professors.

"My father sends you his respects and hopes to see you when you pass on your way South.

"My best regards to all,

"Your humble servant,

"G. VEGA.

"Havana Manique 127."



## SEPTIC SORE THROAT.

By NATHAN WINSLOW, M.D.

During the month of February Baltimore was visited by an epidemic of sore throat which the profession soon realized to be of an unusual type. Unlike ordinary tonsillitis, it was obstinately resistant to treatment, was accompanied in many instances by enormous swelling of the cervical lymph glands, and displayed a marked tendency to secondary involvement of distant structures. The course and characteristics of the malady were so unlike the familiar forms of tonsillitis that the profession early realized it was dealing with something new. As the affection was followed by death in some few instances, it does not seem amiss that the readers of THE HOSPITAL BULLETIN be posted on its symptomatology, apparent mode of transmission, treatment and complications. A peculiarity of the disease in Baltimore, as in Chicago and Boston, where similar epidemics had already occurred, was its following the route of certain dairies. In this city it was observed that most of the cases were limited to patrons of the Hygeia Dairy, and after further investigation it was learned that the milk supplied by this dairy had not been pasteurized during the prevalence of the epidemic, due to a breakdown in the pasteurizing apparatus. The chief interest centering in the malady, however, was the number and seriousness of the complications—enlargement of the cervical glands (with or without suppuration), broncho-pneumonia, peritonitis, pleurisy, nephritis, erysipelas, peritonsillar abscess, otitis media, endocarditis, septic arthritis, etc. It was due to this array of complications, many of which might and some of which did prove fatal, that the attention of the profession was focused upon it. During the epidemic 14 cases came under my care. Of these six were adults and eight children, six males and eight females. In one the cervical lymph glands supplicated after the patient had been ill six weeks. The abscess was opened and drained, and the child then proceeded to make an uneventful recovery. In two there was suppurative otitis media; in two arthritis; the others escaped complications.

In every case observed by me there was a history of a sudden, abrupt, sharp onset, ushered in

with chills, rapidly followed by severe muscular pains and headache. There was rapid rise in temperature, in one case reaching 104.4-5° Fahr. The fever frequently exhibited an intermittent character. A temperature which had been 102° Fahr., or higher, would gradually subside. The patient would be so much improved that visits would be discontinued. In a few days another summons would be received, and the patient would be found presenting the original symptoms, only aggravated. In every instance the throat was red, swollen and congested. In some patients the tonsils were markedly enlarged; in others not apparently involved. In only two of my cases was there a thin grayish membrane on the tonsils. In neither did it entirely cover the tonsils, but occurred in patches. Within a short period after the onset there was swelling of the cervical and submaxillary lymph glands, which enlargement occasionally reached huge proportions. The patients generally complained bitterly of pain upon swallowing. A particularly noticeable feature was the excessive prostration, which was entirely out of proportion to the severity of the tonsillitis.

Bacteriological examinations in Baltimore, as in Chicago and Boston, revealed the presence of a streptococcus presenting peculiar characteristics. The organisms occurred in chains or pairs, and were surrounded by a capsule, which led some observers to believe they were dealing with the pneumococcus. The germ grew abundantly on blood agar.

A noticeable feature of the Baltimore epidemic was the localization of those affected to a well-defined territory. The characteristics of these cases were entirely dissimilar to symptoms of tonsillitis presenting in cases elsewhere in the city. Another noteworthy peculiarity was the limitation of the victims almost entirely to users of the Hygeia Dairy. This fact led observers to believe milk was in some way connected with the malady. When one takes into consideration that 4.6 per cent. of the cows (Capps and Miles, *Journal of the American Medical Association*) supplying milk to the dairy in Chicago whose consumers were afflicted were affected with mastitis from the exudate of which a similar organism was obtained in pure culture, and that farmers and milkers in contact with these cows were afflicted with the same form of sore throat, one naturally concludes contaminated milk to be the medium



through which the human infection occurred. In confirmation of these views the above writers report the recovery of a virulent streptococcus from the milk of a cow and the throat of a girl on the same farm who was ill with sore throat and arthritis.

Considering the number and the seriousness of the complications, the prognosis should be guarded.

Prophylactic treatment consists in examining the cows from which the milk is obtained. If diseased udders are found, the milk should be condemned. During such an epidemic as Baltimore passed through reliance should not be placed in the pasteurization of the milk by the distributing dairies, as it is well known that pasteurization often is imperfect, but all milk consumed should be boiled.

Every line of local throat treatment seemed to be equally unavailing. The simple, ordinary mouth washes, such as salt water, assisted by an occasional mopping off of the infected area with a 5 per cent. carbolic-acid solution gave as good results as any. The antipyretics in my hands were rank failures. Build up the resistance powers of the patient with good, easily-digested, nutritious food. The complications should be treated as such diseases would be treated under ordinary circumstances.

The only case upon which I had to operate developed a suppurative cervical adenitis. The patient, a boy of three years, had been ill for six weeks, when a fluctuation was made out back of the ear. At the time he was running a temperature which fluctuated between 102 and 104 4-5° Fahr. He was operated in the morning. By evening his temperature had dropped to normal and remained there. Drainage was instituted. Recovery was uninterrupted.

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Miss Louise Gephart, University Hospital Training School for Nurses, class of 1911, is superintendent of the Havre de Grace Hospital of Harford County (Incorporated), Havre de Grace, Md.

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Dr. John R. Winslow, class of 1888, is spending a vacation at Edgecliff Hotel, Gloucester, Mass.

## BOOK REVIEWS

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INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of William Osler, M.D., Oxford; A. McPhe-dran, M.D., Toronto; Frank Billings, M.D., Chicago; Charles H. Mayo, M.D., Rochester; Thomas H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harrold, M.D., London; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume XI, twenty-second series. 1912. Philadelphia and London: J. B. Lippincott Company. Cloth; \$2 net.

The present volume is teeming with questions vital to the medical profession, such as Pellagra, a Lecture on the Present Status of Epidemic Poliomyelitis, the Dangers of the Underfeeding of Infants, Direct Method of Examination of the Larynx, Trachea, Bronchi, Esophagus and Stomach, and Cerumen in the Ears.

Perhaps the most important of all the contributions is that by Simon Flexner on the present status of epidemic poliomyelitis. At any rate, owing to the enormous increase and general distribution and present excessive presence of poliomyelitis, it is the most timely. Dr. Flexner rightly states that the medical profession of this country should awaken to the fact that we have amongst us a severe epidemic of this disease. He is also of the opinion there is no telling how long it will remain; therefore, the sooner the profession and the public come to a realization of this, and the fact that the only method we have at present for its control is isolation, the better for all. Since the summer of 1907 epidemic poliomyelitis has extended from the Atlantic seaboard, where it first appeared, throughout the length and breadth

of this country. It was not until 1909 that experimenters were able to transfer the malady to animals—in this instance the monkey—and is done by directly injecting the cerebrospinal fluid from an affected individual directly into the brain of a monkey. This experiment taught us that the incubation period was from three to thirty days, averaging about eight. According to the author, it has been definitely proven that the cause of the disease leaves the body through the pharyngeal and nasal mucosa, and that the disease is contagious. Admitting these conceptions of the disease, he states, its prevention lies in the employment of the same methods used in diphtheria, scarlet fever, etc. The sick should be separated from the well. The discharges which contain the virus must be destroyed, and a sufficient time must be allowed for isolation to make it at least highly probable that the infectious agent has disappeared from the nasal and buccal secretions. Work done on a preventive serum leaves the writer full of hope of finding a therapeutic control for the disease. This article alone is well worth the price of the volume. The article on pellagra is also of more than ordinary merit and can be read with both pleasure and instruction.

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THE PITUITARY BODY AND ITS DISORDERS. Clinical States Produced by Disorders of the Hypophysis Cerebri. By Harvey Cushing, M.D., Associate Professor of Surgery the Johns Hopkins University; Professor of Surgery (Elect) Harvard University. An amplification of the Harvey lecture for December, 1910. 319 illustrations. Philadelphia and London: J. B. Lippincott Company. Cloth, \$4 net. 1912.

Recent investigations of the glands of internal secretion have thrown much light on many maladies whose etiology was heretofore hidden in darkness. Surgery has done much in clarifying the atmosphere. With our present knowledge, however, the explanation of many phenomena remains in darkness. The work done on the thyroid blazed the way for the solving of the part the other ductless glands played in the human economy. One of the last of the ductless rests to be brought into daylight is the pituitary body. Its existence has been known for many years, but its use has remained hidden until a comparatively recent date. Much of the credit for

the solving of its status is due Harvey Cushing of the Johns Hopkins University and his coworkers in that institution. During the past few years Cushing has done monumental work in experimental and clinical pituitary surgery. He has proven some of the theories brought out by brother workers, and disproved many fantastic ideas of the past. Perhaps the most important feature of Cushing's observations on this gland are the variations of the symptoms according to whether the gland is in a state of over or minus activity, and the perfection of a surgical method of attack. Undoubtedly Cushing's investigations upon this organ will stand as a masterpiece of its kind, especially as a basis for future experimenters to follow. Though much is known concerning the activities of the ductless glands, many problems remain unsolved. Those interested in what has been and what is being done in pituitary surgery are fortunate in being able to obtain under one cover and at a moderate price the labors of Cushing and his co-operators on the hypophysis cerebri. The book is an amplification of the Harvey lecture, delivered in December, 1910, before the New York Academy of Medicine. It contains not only the work done up to the date of the delivery of the lecture, but that done since then; a historical review of the subject, anatomy, physiology, morphology, pathological anatomy, organo-therapy, chemistry of the gland, clinical manifestations of disordered function, symptomatology and treatment. Everybody—internist, surgeon, pathologist, chemist, radiologist, neurologist, oculist, gynecologist, etc.—should be interested in this contribution to medical literature, as the symptoms are referable to practically every organ of the body. For instance, in pituitary insufficiency there is interference with vision, amenorrhea, non-development of the genital organs, enlargement of the sella tursica, high carbohydrate tolerance, etc. With these features the volume should appeal especially to those who desire to be abreast of the times, as there is not the least doubt in the mind of the writer that pituitary faults are at present overlooked as much as thyroid were in the past.

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Dr. William Tarun, class of 1900, has been forced to give up his practice for a while because of illness. We wish him a speedy restoration to his usual good health.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, AUGUST 15, 1912.

## DR. ERNEST ZUEBLIN.

There have been many inquiries directed to us concerning Dr. Ernest Zueblin. The editor has frequently been asked who is he, where is he from and what has he done? We therefore take this occasion to publish the data we have in hand.

Dr. Zueblin, Professor (elect) of Medicine in the University of Maryland, after five years of study at Heidelberg, Zurich and Lausanne, was awarded the degree of M.D. from the last institution in 1903. In 1903 and 1904 he did graduate work at Munich under Professors Muller and Bauer; in 1904-1905, he was assistant to Geheimrat Professor Leube at University of Wurtzburg; 1905-1906, assistant to Professor C. Roux at University of Lausanne; 1906-1907, first assistant to Geheimrat Professor W. Fleiner at Heidelberg; 1907-1909, associate physician at the sanitarium of Dr. A. Widmer at Valmont, Territet, post-graduate work at Munich and Berlin under Professors Ewald, Rosenheim and Strauss; 1909-1911, assistant to Professor Max Einhorn (New York), pathologist to Tuberculosis League Hospital, Pittsburgh; 1911, attending physician to Western Pennsylvania Hospital; 1911-1912, attending physician Allegheny General Hospital, Pittsburgh. Dr. Zueblin since graduating from University of Lausanne has been engaged continuously in institutional work in the universities of Europe and the United States. Dr. Einhorn of New York gives him the highest rec-

ommendations, and those who have met him at the University of Maryland have been very favorably impressed with him. As far as can be determined now, he is the man for the place, and his election has been well received by his coworkers to be in the department of medicine. Dr. Zueblin has a very attractive personality, and we feel will soon win the respect, friendship and love of his fellow-workers, students and alumni. It is needless to state after such an experience in post-graduate work that he is eminently fitted for the position. THE BULLETIN extends, in the name of the Faculty of Physic, Adjunct Faculty, alumni and students a most cordial welcome to Professor Zueblin as a member of our Faculty, and bespeaks for him the loyal support of the members of his department.

## AN EXPLANATION.

In the July issue of THE BULLETIN the editorial, "Who Shall It Be," was wrongly interpreted by many. In justice to the medical members on the Board of Regents, the editor feels constrained to explain to the readers of THE BULLETIN that they are on the right side. Each and every one of them stands for progress. They have the best interests of the Medical School and University at heart, and will not stop at anything within their power to advance the University. Those outside the Board of Regents are loudly calling for trustees not connected with the teaching bodies. The editor desires to impress upon the alumni and those interested in the uplift of the University of Maryland that the members of the Faculty of Physic (and this includes the Faculty of Dentistry and the Faculty of Pharmacy) have and are endeavoring to bring this happy result about. They are fully alive to the needs of the institution, as much so as any of us, but how to accomplish the change is what is bothering them. The law faculty is the stumbling block.

These men say they are satisfied with conditions. Their school, unhampered by such expensive requirements as laboratories, clinics, etc., is flourishing. Their expenses are naturally much smaller than those of the other schools. They do not outwardly state, however, that they are apparently interested only in the "come back" they get from the old cow. Sooner or later, as in the case of the School of Medicine, the old cow will

go dry. The Law School is not so strong that it can withstand the stress of competition from a law school of high standard which is bound, sooner or later, to be organized in our midst. At that time the University of Maryland Law School will find itself in an identical plight as that which the Medical School faces today, but it will then be too late to change the organization of the schools.

By "reactionaries" was meant the members of the Law Faculty, and from their present actions it seems they are more interested in their pocket-books than the success of the University of Maryland.

All hail to those members of the Faculty of Physic, who, in order to supply six full-time men, were willing to forego any remuneration for their own services. The editor could not and would not let the impression go forth that they were or are negligent to their trust.

#### VACATION TIMES.

Every schoolboy rejoices when the school bell rings for the last time and he is released from the routine of school life and is free to follow the bent of his own erratic inclination. To those who are older and whose work is of a more serious character vacation time is also none the less pleasant. It is an old and trite saying that "All work and no play makes Jack a dull boy." Not only do school boys and girls require a time of rest and recuperation, but it is very essential that everyone, and especially those who are bearing heavy responsibilities, should have a time in which to refresh their minds and bodies and to drink in new truths at the font of nature. Physicians become so engrossed in their duties that many of them forget to take the necessary time in which to secure a change of scene and surroundings. It is, however, becoming more and more recognized that a physician becomes a more useful member of the community when he takes a reasonable time for his own recreation and instruction.

University work ceased on June 1, and most of the students have scattered far and wide. The closing of the accounts and records of the past session and the preparations for the next session kept the various members of the Faculty in the city until the middle of July, but several have now left on more or less prolonged leave of

absence. Professor Hemmeter is spending the summer in Maine, as the cooler weather of the North is beneficial to his health. Professor Neale, as usual, spends the summer at Ocean City, Md. Professor Gilchrist has gone to England. Professor Ashby has taken a house at Roland Park and will spend the summer at that delightful suburb, while Professor Winslow is again indulging his fondness for travel by making a journey to Cuba, Panama and Central America.

In consequence of the absence of Professor Winslow we cannot present a long list of new subscriptions to the pathological endowment fund, but are pleased to be able to announce several very acceptable contributions, which, if not as large as the donors would like them to be, at least are evidences of their good-will and constructive sympathy. We are engaged in an enormous struggle to put and keep our school on a satisfactory basis. All teachers of practical branches must serve without salary hereafter. We can do no more. If you love your Alma Mater, help us to sustain her.

#### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	70 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	35 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	50 00

1901.....	240 00
1901.....	240 00
1902.....	305 00
1903.....	315 00
1904.....	145 00
1905.....	210 00
1906.....	165 00
1907.....	110 00
1908.....	20 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to August 1, 1912. \$10,136 50

#### NEW SUBSCRIPTIONS IN JULY.

Geo. H. Cairnes, 1864.....	\$20 00
S. Griffith Davis, 1893.....	25 00
Geo. H. Stewart, 1899.....	25 00
Henry Lyon Sinskey, 1908.....	10 00
Total.....	\$80 00

### ABSTRACT

Dr. Watson Smith Rankin, class of 1901, secretary to the State Board of Health of North Carolina, presents an argument (*Old Dominion Journal*, July, 1912) setting forth the value of vital statistics in the work of safeguarding the health of a community, in which he says, in part:

The happy girl of sixteen, in her exuberant health, accepts her greatest blessings as a natural inheritance, as natural as the sunshine, and gives it as little thought. Her attitude to health is one of indifference. Time passes and girlhood fades into womanhood; death knocks at her door; her baby answers the summons; blinded with the bitter tears of sorrow, she falls on Providence. Her attitude to health is one of fatalism. Time moves on, and observation, sharpened with the friction of the years, discerns relationship between pre-existing and subsequent disease, between environment and disease, and slowly there is evolved a consciousness of control over disease-producing factors. Health fatalism recedes as the light of the most powerful fact of the nineteenth century—the preventability of diseases—enters her mind; the spirit of the dead baby calls her attention to the terrible meaning of the needless death, awakens her conscience to its part in the great conflict

of life and death, and a raw recruit enters the army of health workers. Her eagerness to do something will not permit of the development of nature plans. The desire to serve overbalances ability to serve; public health is more philosophy than science. Her attitude to health is one of unco-ordinated enthusiasm, characterized by spasmodic and sporadic efforts to prevent disease. Finally, with the novelty of the new idea worn off, with the sedative effect of the fatigue of sporadic and exaggerated effort, cold reason resumes her throne, and puts the blunt question: Where are the fruits of your labor? Exactly what do you seek? What evidence is there to indicate the value or futility of your effort? The health enthusiast begins to think, to seek some fixed point from which progress may be measured, and vital statistics as an absolute necessity in health work is recognized. With that discovery philosophy gives way to science, and exuberant enthusiasm to steady, rational effort. The attitude to health is rational, scientific.

These four mental attitudes to health—the indifferent, the fatalistic, the enthusiastic and the rational or scientific—are found in varying proportions in the public opinion of different places, and so in accordance with the dominant mental attitude is the attitude of the Government to health work, indifferent, fatalistic, enthusiastic or rational.

The indifferent and fatalistic types of mind are passing rapidly into extinction. God speed them!

The enthusiastic type of mind is still rare enough to be appreciated when found. This type makes a good supporter, but a bad counselor for the health officer. People of this type are visionary; they have schemes for cleaning up the town or county in less time than it takes to bathe a baby; they regard a board of aldermen or commissioners as an absolute and not as a representative power; they waste valuable energy in vain endeavor to scale the heights, rather than take the more circuitous path of popular education that will surely in the end bring them in sight of the promised land; they appraise a health officer by the amount of appropriation that he is instrumental in securing, by the number of speeches he makes, and by the amount of literature he scatters, some by the wayside, some upon the stony ground, and, thank God, some upon good soil.

The scientific attitude to public health recognizes society in its entirety and not as unrelated

fragments, not as so many thousand or million individuals, but as Herbert Spencer saw it, as a unity, a "social organism." To the scientific mind the individual is to the social organism what the cell is to the cellular organism; the industrial or social class to the social organism, what the organs or groups of cells of like function are to the cellular organism. In the one as in the other, units and classes or organs are mutually dependent and bound into a co-ordinated potentiality.

This social organism may become diseased just as the cellular organism, and like it exhibit disease phenomena or symptoms. These disease phenomena or symptoms are as essential in the diagnosis and treatment of diseases of the social organism as they are necessary to the proper diagnosis and treatment of diseases of the cellular organism.

As a symptom in the cellular organism is the expression not of one, but of many cells, so symptoms of disease of the social organism are civic rather than individual expressions. These symptoms are in terms of *per* thousand or *per* hundred thousand population,—in short, in the very nature of the case they must be statistical. Inasmuch as they relate to conditions of life, they are properly called vital statistics. \* \* \*

The doctor who recognizes only the *common* characteristics of a disease and overlooks the *peculiarities* contributed by certain individual factors, and who treats disease by rule of thumb methods, and ignores individual modifying factors, is not to be classed as a first-rate scientific physician. Likewise, the sanitarian who gives the general tonic treatment of sanitary education to every sick town or county, and fails to meet the *special* indications in each particular town or county, falls far short of his opportunities as a health officer.

I repeat, for emphasis, there is a symptomatology of disease of the social organism; it is as necessary in the intelligent treatment of diseases of the social organism as is a knowledge of the meaning of symptoms in the treatment of diseases of the cellular organism. My endeavor in this paper, so far, has been to call your attention to just enough of this symptomatology to show its existence and suggest its inestimable value. It is admitted that the symptomatology of diseases of the body politic is not a perfect science yet. As the symptomatology of personal diseases was relatively simple and undeveloped fifty years ago

as compared with the present, so will develop the symptomatology of public disease in the near future. But even now, the fact should be recognized that a health administration that pursues its course without a close study of symptoms, of vital statistics, is unscientific, pursuing its way without compass or chart on the ocean of life blindly working in the dark, and may find some day, when the light of truth breaks through the clouds of ignorance, that all its building has been on the shifting sand of opinion, and not upon the rock of eternal fact. My first point then is, that scientific health work must rest on a basis of vital statistics, and that such statistics are in their meaning analogous to the symptoms of personal disease.

Another value of vital statistics, second only to their value in the intelligent treatment of disease of the social organism, is their influence in removing public health work from politics. Once the people have grasped firmly the fact that a health officer is one who reduces death rates or increases average longevity, the health work of this country will be established upon a basis of genuine merit and not upon popular whim or political favor. A government that re-elects, elects or maintains any person who has not or does not show the effects of his work in a definite saving of human life and health, will never be tolerated. The health officer who can "deliver the goods," pardon the slang for its expressiveness, will be in demand, can command his own salary, and even better than that, deserve it. When that good time comes the best minds in medicine will be shifted from curative to preventive medicine, the newest specialty will be the greatest specialty, the specialty that pays best and affords the greatest opportunity for glorious achievement—public health will have come into its own.

In conclusion, the only method of health work that will ever be effective must rest upon a system of facts furnished by vital statistics.

The ideal in the public health work of this State for which we incessantly long is a State-wide enforceable vital statistics law, that, with the powerful pressure of public opinion and that primal instinct, self-preservation, will make it impossible for the State itself to ever become afflicted, for any length of time, with a public health administration that cannot justify its existence in a decrease in the State's death rate—

the absolute test of efficiency in health administration; that will make every one of the one hundred county health officers of this State competitors in a great life-saving contest with the other ninety-nine; that will forever divorce public health work from politics; that will give the health officer the exact recognition, rating and compensation that he merits as indicated by the death rate of his constituency; that will make public health work as attractive to strong men as it is needed by a grievously and needlessly sick social organism; that in the course of a few years will change the death rate in North Carolina from 18.4 per thousand to 12 or 13 per thousand, which means the saving of ten thousand lives a year with the concomitant amount of sickness, suffering and anxiety that goes with so great a loss of life; an ideal that will at least suggest that ecstatic vision wherein the old ideals and old order of things have passed away, and, in their place, a new heaven and a new earth adorned as a bride for her husband.

[EDITOR'S NOTE.—Dr. Rankin's comment on a health officer who can "deliver the goods" is perhaps borne out in Boston's recent appeal to the physicians of America to enter the lists for chairmanship of her Board of Health. Everywhere a call is being made for competent men, and places await them.]

## ITEMS

Dr. William J. Todd of Mount Washington has the following to say of Dr. Horatio Gates Jameson, Jr., and thus adds to our history of the descendants of Dr. Jameson of the class of 1913:

Horatio Gates Jameson, youngest son of Horatio Gates Jameson and Catherine (Shevell) Jameson, was born in Baltimore, October 1, 1815; graduated at the Ohio Medical College in 1836; commenced the practice of medicine in Cincinnati, then to Baltimore city, later at Church Hill, "on the high road running between Elkton and Easton," in Queen Anne's county, Maryland, in 1841. Dr. Jameson continued to practice medicine on the Eastern Shore until about 1843, when he removed to Baltimore city, thence to Baltimore county, locating at Brooklandville, on the Rider estate; then to the village of Rockland, on the Falls road turnpike, living in an old stone house, lately remodeled and occupied by Mr. Bryan, the owner of Rockland Flour Mills. August 23,

1856, Dr. Jameson bought a small tract of land on Bare Hill from Mr. Johnzey Hook, known then as "Hector's Hop Yard," upon which he built the large and comfortable house lately owned by Mrs. Jane Wright. Dr. Jameson died in this house of tuberculosis in August, 1865.

His wife was Sarah McCulloh Porter (married in 1841), daughter of Parnell and William Porter, a merchant of Baltimore city. She survived him only a few weeks, dying at the house of her sister, Mrs. William Hanna, in Baltimore city. There was only one child by this union, a daughter, Kate, who died about the age of six years.

Dr. Jameson was a man of versatile accomplishments. He was musical, playing skillfully upon the flute, his favorite instrument. He was also an artist of some note.

He was tall, slender and inclined to stoop shoulders; had a deep, musical voice; very amiable and mild in manner. As might be expected of one who was a painter and musician, he was exact as to the carrying out of the details in the treatment and nursing of his patients.

A lady who recalls Dr. Jameson states: "He was the first physician to use a buggy in this section; he had a large practice, requiring long drives."

Indirectly, the death of Dr. Jameson was due to a severe wetting he received while on his way to see his patients. He was crossing Jones Falls on horseback, when a washerwoman flaunted a piece of the wash in the face of the doctor's horse, which became frightened and unmanageable, throwing the doctor on his back into the water. Not heeding the fall and the wetting, he continued on his way, seeing several patients, returning home late, with his clothing wet and he chilled. From this accident and exposure he contracted a severe cold, from which he never recovered, and which, no doubt, was the primary cause of his death.

The late Thomas Wright of Rockland remembered this man, and called upon him for medical advice. Dr. Jameson saw his patients professionally almost to the day of his death.

After the death of Mrs. Jameson their homestead was purchased by Dr. Steele, who remained a short time, and then sold to Admiral Porter, whose mother, with another son, spent the last years of her life there.

Dr. Jameson was a descendant of a David Jameson, a graduate of the renowned University of Edinburgh, who emigrated to this country

about 1740, landing in Charlestown, S. C. Leaving there, he settled in Pennsylvania. His descendants of the fourth and fifth generation resided in Shippensburg and at York. In 1796 he was living and practicing his profession in Shippensburg, Pa., where it is believed he died. David Jameson was lieutenant-colonel of the Provincial forces and colonel of the Revolutionary forces of Pennsylvania.

His commissions as captain, brigade-major and lieutenant-colonel, also as colonel of militia of Pennsylvania during the Revolutionary War, are in the hands of his maternal great-grandson, who is Horatio Gates Gibson, Colonel Third Regiment Artillery and Brevet Brigadier-General of United States Army, Washington Barracks, Washington, D. C. Of this man's children, two sons, Horatio Gates and Thomas, followed the profession of their father. Thomas settled in York, Pa.

Dr. Edward Sanborn Smith, class of 1900, of Macon, Mo., is spending a unique vacation cruising in the Mississippi and its branches. He is accompanied by his friend, Harry M. Rubey, president of the Rubey Trust Co. of Macon. The two left St. Paul, Sunday, July 15, to cruise down the Mississippi to Grafton, then up the Illinois River, through the Illinois-Michigan Canal and Chicago River, across Lakes Michigan and Huron to Georgian Bay, Canada, and back to St. Paul, in all some three thousand miles. The trip is being made in the 50-foot launch Elizabeth. Dr. Smith will have charge of the engine-room. Mr. Rubey will be the skipper. The bill of fare for the voyage will be "jest plain country eatings"—fish, roast beef and corn, corn dodger, molasses, potatoes and strong coffee. Dr. Smith says: "The purpose of our voyage is to study navigation, to hunt up picturesque shore lines and to take good pictures of the natives and the scenery. If our adventures justify it, I'll order the cook to write a book about them between meals. Should we be boarded by pirates, we have a phonograph which sings Casey Jones and other deadly weapons for self-protection." The Elizabeth has a luxurious library, state and observation rooms, but the greatest attention has been paid to the motive power and steering apparatus. The boat on a smooth course will easily cover 12 miles an hour. We wish Dr. Smith much enjoyment from his "simple life outing."

The University of Maryland record at the recent State Board examinations is as follows:

Number.	Class.	Anatomy.	Surgery.	Pathology.	Obstetrics.	Practice.	Chemistry.	Materia Medica.	Therapeutics.	Physiology.	Total.	Average.
4	1912	75	100	85	97	80	75	78	86	90	766	85
9	1911	71	75	88	87	65	75	69	67	77	775	86
11	1911	84	98	86	87	84	88	88	84	88	775	86
12	1912	77	90	76	71	82	67	82	61	75	696	77
23	1912	71	88	80	88	75	79	75	70	79	705	78
44	1912	86	75	92	90	82	65	68	79	70	707	78
48	1912	75	90	81	94	75	80	79	84	80	738	82
49	1912	94	90	96	97	87	90	88	94	88	824	91
53	1912	47	90	79	70	75	71	50	0	72	554	62
54	1912	94	85	88	89	75	79	75	88	85	758	84
57	1912	54	85	77	79	75	59	67	67	63	634	70
59	1912	80	90	88	89	75	67	84	68	716	80	80
61	1912	84	90	96	92	78	80	76	71	75	745	83
66	1912	87	76	93	94	76	75	83	75	96	751	84
67	1905	75	..	78	..	..	..	..	..	..	..	..
83	..	82	..	..	..	..	88	92	..	82	..	..
87	1912	89	95	94	92	82	79	93	90	87	801	89
88	..	87	..	..	..	..	94	86	..	94	..	..
91	..	87	..	..	..	..	87	86	..	95	..	..
92	1912	75	80	91	81	83	81	73	76	79	724	80
93	..	79	..	..	..	..	89	88	..	91	..	..
96	1912	64	90	67	75	75	80	80	75	72	668	74
97	..	87	..	..	..	..	89	75	..	82	..	..
98	1912	64	92	93	94	75	75	87	86	741	82	..
103	..	80	..	..	..	..	82	87	..	90	..	..
105	..	89	..	..	..	..	83	81	..	90	..	..
114	1912	80	96	86	94	75	79	66	55	75	706	78
115	1912	64	92	83	55	75	75	79	58	75	656	73
125	1912	72	95	75	88	80	73	63	69	85	700	78
137	..	83	..	..	..	..	86	90	..	84	..	..
141	1912	74	85	74	75	75	73	75	77	68	676	75
142	..	65	..	..	..	..	76	57	..	41	..	..
143	1912	76	84	87	94	75	75	80	75	80	726	81
148	..	87	..	..	..	..	78	67	..	76	..	..
149	..	80	..	..	..	..	79	80	..	85	..	..
150	1912	90	90	95	94	81	92	81	77	93	793	88
151	..	73	..	..	..	..	80	75	..	84	..	..
152	1912	92	80	97	94	84	75	87	81	75	765	85
153	1912	77	84	96	91	79	88	84	92	86	777	86
158	1912	91	80	72	91	75	65	79	75	85	713	79
159	..	75	..	..	..	..	82	70	..	75	..	..
160	..	63	..	..	..	..	71	54	..	57	..	..
161	..	85	..	..	..	..	81	76	..	75	..	..
162	..	84	..	..	..	..	75	75	..	96	..	..
163	1912	89	84	99	92	75	88	75	96	89	787	87
165	..	90	..	..	..	..	89	68	..	83	..	..
166	1912	83	84	85	91	82	85	86	87	85	768	85
167	1910	..	..	82	..	..	75	..	..	78	..	..
171	..	74	..	..	..	..	79	..	..	66	..	..
177	1911	76	..	96	95	..	85	..	76	..	..	..
181	1912	80	87	86	93	75	86	69	74	93	743	83

The staff of the University Hospital for 1912-1913 is as follows:

Medical Superintendent—William J. Coleman, M.D., class of 1908.

Assistant Resident Surgeons—F. R. Winslow, M.D., class of 1906; Robert E. Abell, M.D., class of 1912; William E. Gallion, Jr., M.D., class of 1912; Edward A. Looper, M.D., class of 1912; Henderson Irwin, M.D., class of 1912.

Assistant Resident Physicians—Charles W. Rauschenbach, M.D., class of 1912; R. A. Allgood, M.D., class of 1912; Wilbur M. Scott, M.D., class of 1912; Judson E. Hair, Jr., M.D., class of 1912.

Assistant Resident Gynecologists—William L. Byerly, M.D., class of 1911; L. K. Walker, M.D., class of 1911.

Resident Pathologist—M. L. Lichtenberg, M.D., class of 1912.



The various newspapers of Baltimore are advocating former Governor Edwin Warfield as the choice of the majority of the officers of the University for Provost to succeed Bernard Carter, provided he is able to give sufficient time to the needs of the University. The Board of Regents meet in September, and have as yet given no indication of the course to be pursued by them.

Dr. J. Holmes Smith, professor of anatomy and clinical surgery, and Dr. J. Howard Maldeis, lecturer in histology and embryology, will in future devote their entire time to teaching and will discontinue the practice of medicine.

Criticism doesn't hurt an institution founded on solid merit. Out of the smoke of discussion we may expect a greater University of Maryland to arise.—*Evening Sun*, August 12.

Dr. William Enrick, class of 1902, now located in Brazil, is a guest in Baltimore.

Dr. Frank Lynn, class of 1907, is out of town because of ill health.

The president of the board of directors of the Skin and Cancer Hospital of Maryland has announced the following appointments of our alumni:

Surgeon-in-chief, Dr. George Hauer Everhart, class of 1890.

Surgeons, Drs. Robert Bay, class of 1905; E. H. Kloman, class of 1910, and Hoagland Cook Davis, class of 1902.

Consultants, Drs. Eldridge C. Price, class of 1874; William Dulaney Thomas, class of 1887; Wilbur F. Skillman, class of 1900; Clarence K. Jump, class of 1885, and George Latrobe Ewalt, class of 1900.

Dr. Jurgi Elias Sawaya, class of 1910, is located at 628 San Martin, Buenos Ayres, Argentina.

Dr. J. A. Hughes, class of 1909, is located at Strong, Northumberland county, Pennsylvania.

Dr. William Royal Stokes, class of 1891, is recovering from a severe attack of malaria, although it will be some time before he is able to

resume his work at the Department of Health. The *Baltimore Sun* writes of him:

"In addition to his work at the Health Department, Dr. Stokes has the chair of bacteriology at the College of Physicians and Surgeons, which is connected with the Mercy Hospital. He is also bacteriologist for the State Board of Health.

"He organized the bacteriological laboratory at the Health Department soon after the election of Mayor Hooper, and has developed it gradually as funds were provided by the city. It is now regarded as one of the best equipped laboratories in the country. Physicians from New York, Chicago and other cities have commended it. Dr. Stokes devotes all his time to the work. For some time he has been directing the manufacture of serum for the prevention of typhoid fever.

"The study of bacteriology is a hobby with Dr. Stokes. No matter how often the administration changes politically, there is never mention of a successor to him. Health Commissioner Bosley recently remarked, on being asked if Dr. Stokes would retain his position: 'You bet he will. I would almost as quickly think of having no Health Department as I would of having a Health Department without Stokes.'"

Dr. Gilbert Tyson Smith, class of 1897, was recently a guest in Baltimore, and while stopping at the Baltimore Athletic Club told of his recent adventures and his future plans. Dr. Smith spent last year along the eastern coast of Alaska as surgeon to the Alaska-Canada Boundary Survey. Most of last winter was spent at Rampart House, a trading post, 250 miles up the Porcupine River, a tributary of the Yukon. Last fall an epidemic of virulent smallpox broke out among the native Indians, and he was put in charge of the situation by the Canadian Government. He stamped out the disease, and lost but one of the 98 patients suffering with the disease. To eradicate the germs Dr. Smith destroyed by fire the cabins occupied by the Indians, and even burned the hospital which the Government had erected at a cost of several thousands of dollars. But the necessity for this severe measure was so great that his course was received with commendation by Alaska and Canada alike. He is now in Ottawa, Canada, preparing for a hunting trip in

the far Northwest in the spring. He will travel through Europe during the winter months.

For his trip in the spring he has purchased the *Vera*, one time a San Francisco man's yacht, later an opium smuggling craft, and perhaps yet to see her weirdest adventures under his guidance. The ship lies in harbor at Victoria, B. C. The first stop will be Nome, Alaska, which Dr. Smith expects to reach in three weeks after starting. Then, as Dr. Smith says: "Hunting big game along the coast, as well as inland, we shall make our way gradually north of Alaska into the Arctic Ocean, with Banksland as our goal. There we will camp for the winter. For months we shall be frozen in, so to speak, in the Arctic night.

"Hazardous? Yes, extremely so; but it appeals to me, and if I must die I should as soon be buried under Arctic ice as in Greenmount Cemetery. I am unmarried and footfree. Were it otherwise, of course I would not think of going. But it is no trip for a man who fears a rough, harsh life, far beyond the luxuries of civilization.

"While my main purpose will be to hunt, I expect to do some little exploring, for, if lucky, I will reach that part of the world of which practically nothing is known. No, I will not try for the Pole, for I am a rival of neither Peary nor Dr. Cook."

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Dr. Andres Martin, class of 1912, writes from Havana that the Cuban situation "is getting better every day."

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Current report says that Dr. Josephus Arthur Wright has been appointed superintendent of Sydenham Hospital, but we have not as yet been able to corroborate the statement. Dr. Wright is a graduate of the class of 1881.

After graduation from the University of Maryland he became physician in charge at the Confederate Soldiers' Home, Pikesville, where he remained four years. Leaving the home, he practiced on the Eastern Shore, returning to Baltimore five years ago to become assistant resident physician at Eudowood Sanatorium. He lives with his son, Dr. Arthur L. Wright, class of 1908, 2505 W. Pratt street, assistant surgeon for the Baltimore & Ohio Railroad Co.

Dr. Wright is 52 years old. He received his early education in the public schools of Wicomico

county. Dr. Wright was a member of the Phipps Dispensary staff of Johns Hopkins during the time he was connected with Eudowood Sanatorium.

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The following alumni successfully passed the Maryland State Board examinations held in June:

Robert Alexander Bonner, Charles Peter Claunce, John Dade Darby, Harry Deibel, John William Ebert, Ernest William Frey, Dawson Orme George, William Granville Haines, Judson Elam Hair, Jr., James Edward Hubbard, John Kent Johnston, Edward Sooy Johnson, Edwin Paul Kolb, Moses Louis Lichtenberg, William Michel, Benjamin Newhouse, Roger Vinton Parlett, Charles William Rauschenbach, Jay D. Sharp, Thomas F. A. Stevens, John Henry Trauband, Jr., William Howard Yeager, all of the class of 1912.

Alvah Parrish Bohannon, class of 1905.

Henry Benedict Athey, class of 1911.

John Francis Bryne, class of 1910.

Samuel Hopkins Cassidy, class of 1911.

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Dr. Thomas Boyle Owings is seriously ill at his home, Owings Glen, near this city. Dr. Owings was born at Roxbury Mills, September 24, 1830. He was the son of the late Dr. John Hood and Mrs. Amanda Clementine Owings. He was educated in the public schools of this county, and, after reading medicine under his father, entered the University of Maryland, from which he graduated in 1852 with high honors. He first located on the Baltimore county side of Ellicott City shortly after he graduated. He served as County Commissioner for about 25 years. Dr. Owings was twice married. His first wife was Miss Margaretta Clark, daughter of the late David and Maria Clark, of Howard county, and his second wife, who is now living, was Miss Nellie Polk, daughter of the late Col. William C. Polk, formerly of Delaware, and Mrs. Sarah A. Polk, who now resides at Sykesville, Carroll county, and who is in her 93d year.

In 1868, the time of the great flood along the Patapsco River, when the larger portion of Ellicott City was washed away, Dr. Owings' first wife, six children and several servants, together with his house and contents, were washed down the river by the raging waters. The present Mrs. Clarence W. Watson of West Virginia, wife of

Senator Clarence W. Watson, and Dr. Clark Owings of Boston, Mass., were the only members of Dr. Owings' family except himself to escape death at this time, and the reason for this was that they were away from home, visiting at their grandfather's. Dr. Owings was away answering a professional call, and arrived at the bank on the Patapsco just in time to see his house, with his family and servants sitting on the roof, carried down by the flood. Dr. Owings was almost crazed with grief, and it took the best efforts of those along the river to prevent the doctor from plunging into the flood in a useless attempt to save those that were dear to him.

Dr. Owings retired from active practice in 1911, owing to ill-health, but at that time he had rounded out 60 years as a practicing physician.

We sincerely wish for Dr. Owings a restoration to health and usefulness in the community he has helped so many years.

Dr. Thomas J. Murray has opened an office at 104 East Main street, Meriden, Conn.

The staff of nurses of the Annapolis Emergency Hospital resigned in a body July 31. Miss Rosamond Minnis, University Training School for Nurses, class of 1907, who led the retiring body, had been in charge of the hospital for some time. She will become superintendent of the Atlantic Coast Line Hospital at Rocky Mount, N. C. Miss Alice Frances Bell, University Hospital Training School for Nurses, class of 1907, will succeed Miss Minnis as superintendent of the Annapolis Emergency, entering upon her duties September 1.

Dr. Ralph Steiner, class of 1883, 607 W. 7th street, Austin, Tex., is president of the State Board of Health of the State of Texas, with headquarters in Austin.

Dr. Claude Jackson Stallworth, class of 1912, of Beatrice, Ala., has been elected resident physician of the Presbyterian Eye, Ear and Throat Hospital of Baltimore, succeeding Dr. William Gee, resigned. Dr. Stallworth was educated in the public schools of Alabama and the Daphne State Normal College, graduating there with honors in 1908. He then studied three years in the Atlanta College of Physicians and Surgeons, entering the University of Maryland in his senior

year. Dr. Stallworth has just passed with a more than creditable average the examination of the State Examining Board of Medical Licensure for Alabama.

Dr. Charles Wesley Roberts, class of 1906, of Douglas, Ga., sent us "case report for THE BULLETIN, check for two years' subscription to THE BULLETIN and best wishes for all my teachers and friends connected with the University." A fat envelope like that gladdens the hearts of the recipients and all who know its contents.

## MARRIAGES

Dr. Gaius William Billups, class of 1906, of 2224 W. North avenue, was married July 24, 1912, to Mrs. Josephine Long, daughter of Capt. G. M. Mullin. The ceremony was performed at the Church of the Prince of Peace, Walbrook, the assistant rector, Rev. James Grattan Mythen, officiating. The bride wore a blue serge traveling dress, with hat to match, and was attended by her sister, Mrs. Nathaniel G. Sexton, as matron of honor. The best man was Dr. Edgar Shirley Perkins, class of 1907. A wedding breakfast was served at the home of the bride's sister, Mrs. William J. Brown. The couple left for a wedding trip to Cape May, and will reside at 2224 W. North avenue upon their return.

Dr. Louis Harriman Douglass, class of 1911, a resident physician of the University Hospital, and Miss Helen Rowles of Parksley, Accomac county, Virginia, were married at Towson on Tuesday, July 30, 1912. The ceremony was performed by Rev. W. H. H. Powers, rector of Trinity Protestant Episcopal Church. Mr. and Mrs. J. S. Downing served as attendants. The bride was a guest of Dr. Douglass' parents, having come to Baltimore to attend the Democratic Convention. She and Mrs. Downing were students together in the Nurses' Training School of the Maryland Homeopathic Hospital. Dr. and Mrs. Douglass were the attendants at the wedding of the Downings last December.

Dr. John Joseph Carroll, class of 1905, of 185 Chestnut street, Holyoke, Mass. (formerly of 120 Chestnut street), was married June 15, 1905, to Miss Joanne Marie Sullivan. There were no cards, the wedding being very quiet, owing to illness in the family of the bride.

Dr. James Edward Hubbard, class of 1912, and Miss Lillian E. Godwin, daughter of Mr. and Mrs. James C. Godwin of Easton, Md., were married on July 17, 1912, at 6 A. M., at the home of the bride's parents in Watson, the Rev. W. H. Litsinger of Calvary Methodist Church officiating. The ceremony was witnessed by the immediate relatives only. A wedding breakfast was served at the house, and the couple left on the early morning train for the North. They will reside in Easton until October 1, when they will remove to Baltimore, and Dr. Hubbard will enter upon his duties as resident physician in the James Lawrence Kernan Hospital for Crippled Children.

Misses Katherine T., Elizabeth D. and Marie M. Barron.

Dr. Barron was buried on Tuesday, August 6, requiem mass being celebrated at St. Ann's Catholic Church by Rev. Lucius Johnston. Burial was in St. Mary's Cemetery at Govans-town.

## DEATHS

Dr. John Addison Moorman, class of 1868; Bellevue Hospital Medical College, '73, a member of the Medical Society of Virginia, formerly of Haleford, Va., died at his home at Hendrick's Store, Va., July 16, 1912, from nephritis, aged 68 years.

George R. Patrick, class of 1879, a member of the A. M. A. and a practitioner of high rank in Gaston county, N. C., died at his home in Lowell June 19 from cerebral hemorrhage, aged 57 years.

We regret exceedingly to announce the death of Mrs. Nora Gorman Ballenger, wife of Dr. Edgar Garrison Ballenger, class of 1901, of Atlanta, Ga., July 18, 1912. Mrs. Ballenger was a daughter of Mr. William H. Gorman of Catonsville, and a niece of the late Senator Arthur Gorman of Maryland. She married Dr. Ballenger in April, 1904. Death was due to typhoid, from which Mrs. Ballenger had been ill for several weeks. Interment was in Loudon Park Cemetery. She is survived by her husband and a little son and daughter.

Dr. John Barron, class of 1877, died at his home, 2236 Barclay street, August 3, 1912, of heart failure. Dr. Barron was born in Clonmell, Ireland, March 26, 1843. His parents emigrated to America in 1845. He was educated at Loyola College and St. James' Institute, matriculating at the University in 1844. He practiced for a time in Philadelphia, later locating in Govans-town, where he practiced for over 30 years. He is survived by a widow and three daughters—

William Porsons Ivey, class of 1883, died at his home in Lenoir, N. C., June 28, 1912, from cerebral hemorrhage, aged 55 years. Dr. Ivey was for many years assistant superintendent of the Morgantown State Hospital and a member of the State Board of Health. He was a member of the Medical Society of the State of North Carolina.

Dr. Henry Rowland Walton, class of 1850, for 60 years a practitioner of medicine in Annapolis, died shortly before midnight August 8, 1912, at his home on Francis street of general debility. Dr. Walton was born in St. Mary's county February 29, 1828, the son of the late Col. John Walton and Mary Egerton Duke. On his mother's side he was a direct descendant of Leonard Calvert and of Duke, who came to Maryland with Leonard Calvert on the Ark and Dove in 1634. He was 84 years old. He graduated from St. John's College in 1847 and from the medical school of the University of Maryland in 1850. Then he spent two years under Professor Charcot in Paris. He returned to Annapolis and began active practice, which was uninterrupted until he became too feeble to attend to his patients. It is said that Dr. Walton was one of the first, if not the first, physician in Maryland to administer an anesthetic. He married Miss Julia Ballard Kent, daughter of Governor Kent of Maryland. She died some years ago. His surviving children are Misses Catharine and Agnes Walton and Messrs. J. Alphonsus and Lawrence Walton, all of Annapolis. He was buried from St. Mary's Catholic Church, Annapolis, Monday, August 10.

John W. Field, M.D., class of 1860, for many years postmaster of Chincoteague Island, Va., a member of the Virginia Legislature from 1865 to 1867 and at one time a member of the Maryland and Virginia Boundary Commission, died at his home on Chintoteague Island, May 4, 1912, aged 75 years.

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No. 7

## A SUMMER CRUISE ON THE SPANISH MAIN.

By RANDOLPH WINSLOW, M.D.

### I. *New York to Colon via Jamaica.*

Colonel Goethals, the chief engineer of the Panama Canal, several months ago gave notice, that those who wished to see the construction work of the canal before the water was turned in would have to be in a hurry to do so, as the actual work of excavation was practically finished. This is therefore my excuse for making a trip to the tropics in midsummer. As a matter of fact, I found I had chosen the most favorable time for visiting the Isthmus and the adjacent lands. There are four steamship lines plying between New York and Colon, but I have no regret in having chosen the Hamburg-American Line steamship, Prinz August Wilhelm for the voyage. The ship is staunch and comfortable, though not speedy. The officers are vigilant, capable and affable, and the cuisine is excellent and abundant. The staterooms are large, and are kept cool with electric fans, and every effort is made to keep the passengers contented and happy. Promptly at 2 P. M. on July 13, 1912, the hawsers were cast off, and we started on our 25-day cruise. To my surprise, the passenger list was quite large, and consisted of a number of persons returning to their work in Cuba and the Canal Zone, as well as tourists, salesmen, natives of the Spanish-American countries and travelers of various races and tongues. Passing down the Jersey coast, the Barnegat light blinked us a cheerful *bon voyage*, and for the next four days we pursued an almost due southern course upon a smooth sea, passing San Salvador, or Watling's Island, which is supposed to have been the first land discovered by Columbus in 1492, early on the morning of July 17. Some hours later we

came to a stop at Fortune Island, one of the Bahamas, where we took on 36 negro laborers, as well as fresh fish. This is a small island inhabited almost entirely by blacks, who eke out an existence by fishing and serving as stevedores on the ships. These men are taken aboard when the ships go south, and are put off on the return trip, after having earned enough ready money to meet their needs for several weeks. The scene from the ship is very pretty: the green foliage of the island in a setting of marine blue, the white houses embowered in palm groves, and the hurrying boats filled with dark-skinned natives, made a typical tropical picture. We did not go ashore, however, and soon the rythmical chug of our propeller indicated that we were again on the move. The short stop, however, was an agreeable break in the monotony of the voyage. After passing Castle Rock Lighthouse we were again in the open ocean, and the fresh southeast trade winds kicked up a rough sea. The Bahamas are a large group of small islands lying off the coast of Florida and the eastern end of the Gulf of Mexico, belonging to Great Britain and inhabited mostly by negroes. They are said to be delightful places in which to spend a winter vacation, with an abundance of wild fowl for the hunter and waters teeming with splendid fish. We were now approaching the coast of Cuba, and Cape Maisi, the extreme eastern end of the island, was passed in the night. Early on the morning of July 18 we were running along the desolate-looking and rugged southern coast of the province of Oriente, made famous by the blockade of the American fleet in 1898. About 9 o'clock we passed through the narrow entrance to Santiago harbor, and shortly thereafter cast anchor. Owing to a quarantine declared by Jamaica against Cuba on account of a few cases of plague at Havana, we were not allowed to land, and we spent the day, like Moses, viewing the promised land from afar. This was much to be regretted, as Drs. Infante,

Brooks and Sagebien came out in a motor-boat to meet us, and they could neither board the ship nor could we accept their highly appreciated courtesy. Passengers who did not expect to go farther on the ship were permitted to land. From 9 in the morning to 6 in the evening we lay in the harbor unloading freight into scows, and then made a bee-line for Kingston, Jamaica. When I reached the deck early the next morning the mountainous coast of Jamaica was in full sight, and not long thereafter Kingston harbor was approached. The coast here is dangerous, and several wrecks were in sight. Kingston is situated on a bay which is separated from the sea by a long sickle-shaped spit of land forming almost a semi-circle several miles in length and only a few

Steaming up the harbor we passed the United Fruit steamer *Mandeville* hard aground on a sand bar, and upon our return two weeks later we found her in the same unfortunate predicament. We landed at Kingston about 9.30 A. M., and were almost at once surrounded by a clamoring mob of dusky coachmen, who were most persistent in their solicitations, and would not take "no" for an answer. Their favorite expression was, "Doc., here is your carriage," or "Take you up, Doc.?" I do not know why they suppose all the white male passengers from the ships to be doctors. The weather was hot, and as there had been no rain for nearly six months, the streets and foliage were white with dust. The city was almost entirely destroyed by earthquake and fire



KING STREET, LOOKING NORTH, KINGSTON, JAMAICA.

hundred feet in width. This acts as a breakwater, and never mind how rough the water is on the outside, ships are safe when in the harbor. On the end of this tongue of land is situated Port Royal, formerly a large town of ill-repute, but after various catastrophies by earthquakes and otherwise, it is now only a British military and naval establishment. About 200 years ago Port Royal was destroyed by an earthquake, and a large portion of its site was submerged in the sea. There is a tradition, probably apocryphal in character, that for a long time the houses could be seen at the bottom of the sea as ships passed over them. We were subjected to a rigid quarantine examination, but were permitted to land, and in that respect were more fortunate than the passengers of the *Prinz Joachim*, of the same line, who were held up several days two weeks later.

two or three years ago, but the houses have been rebuilt with reinforced concrete, hence are supposed to be both fire and quake proof. The business houses and public buildings are quite fine structures, and the residences are pretty bungalows surrounded by beautiful flowers and vines. The Myrtle Bank Hotel is a large structure of the Spanish mission style of architecture, beautifully situated on the bay, where the fresh sea breeze blows constantly during the day and a land breeze at night. We had an opportunity to attend a dance at the hotel, and to see fashionable society in this colonial metropolis. The guests at this function were all white, the ladies were dressed in the height of style, and some of them were very handsome, and the gentlemen were fine-looking men, who looked very uncomfortable in full-dress suits. Dancing was evidently hot work, as there

were long intermissions between the dances, during which the parties sat under the trees and cooled off. The population of Jamaica is 98 per cent. negro, varying from nearly white to jet black in color. Many of them are good-looking, well dressed and educated, the majority, however, are plain "niggers." Negro women, barefooted and scantily attired, come long distances, carrying large baskets filled with vegetables and fruits on their heads, or driving diminutive donkeys so heavily laden with produce as to almost hide the animals from sight. The stores are good, and merchandise is reasonable in price, owing to the absence of duty. The clerks, and often the proprietors, are mulattoes, but one receives polite attention and good service.

I embarked in one of the latter craft and drove around the city. As has been said, the long-continued drought has parched the foliage and caused much dust and discomfort, but wherever there was water the flowers were abundant and the yards attractive. The Governor lives on the edge of the city at the King's House, which is a new concrete building erected since the earthquake. Here in a spacious home, with large, airy rooms filled with solid mahogany furniture, a splendid swimming pool and ballroom, and beautiful lawns and grounds, His Excellency is able to pass away the time in a pretty comfortable manner. The policemen are all negroes, and not only do they perform their duties effectively, but they are very striking-looking in their uniforms of white coats



HARBOUR STREET, KINGSTON, JAMAICA.

One local custom is somewhat embarrassing and inconvenient to visitors, especially those whose stay is very limited, and that is the closing of stores at 4 P. M. Upon our return trip a number of passengers wished to make purchases, but we arrived just as the stores were closing, and as the next day was a holiday, we were unable to spend some of Uncle Sam's good money and had to bring it back with us. I may say here that American money passes current everywhere in these parts, and when they give the price as so much "gold," it means our currency, whether coin or bank bills. There are several street-car lines, and one can get a good idea of the appearance of the city and of the people by investing a few pennies in car rides, or, better still, by taking one of the rattling vehicles drawn by rat-like ponies. Being enticed by the siren song of a dusky Jehu,

and helmets and dark blue pantaloons, with broad red stripes down the legs. I saw two of them haling a young buck to the lock up; the policeman seemed to enjoy the occasion, but the culprit was wailing loudly. Tropical fruits in abundance are to be had at a small cost, cocoanuts just off the trees, pineapples just plucked and sweet as honey, mangoes, alligator pears and other fruits that are but seldom seen in our country. On the other hand, lemons are not to be had, and limes are used instead, and oranges are scarce. The great fruit product of Jamaica, however, is the banana, and an enormous traffic is carried on in this palatable and valuable food fruit. The loading of a fruit ship with bananas at Kingston is a sight not to be forgotten when once seen. We took on 27,000 bunches of bananas at Kingston. They are harvested when still very unripe, green and



hard, and are brought in trains to the dock; here they are unloaded and carried by negro men and women on their heads to the ship, where they are piled up carefully in refrigerated holds. These banana loaders are mostly as black as coal, wear a minimum of ragged clothing, and sing and curse and babble in a jargon that is unintelligible to the visitor. They frequently stop to quarrel, and sometimes to fight, and during our visit a number of women got one of the foremen down and gave him a good beating. The foremen also are impartial, and club the women as freely as they do the men. Several hundred of these people lying like animals on the wharf asleep, or later shouting, singing and cursing, as well as polluting the atmosphere with malodorous effluvia, made a Plutonic scene indeed. While standing on the deck waiting for the ship to leave I was addressed by a gentleman who recognized me, but whom I did not know. He was Dr. Mindis, a graduate of the Dental School, who is living and practicing his profession in Kingston.

The trip from Kingston to Colon takes about 48 hours, and is by no means a pleasant one, as the Caribbean Sea is always a rough stretch of water, and many people pay tribute to Neptune. I did not miss any meals or pay the above-mentioned tribute, but I was glad to see the shores of the Isthmus on the morning of July 22, and to disembark at Colon a few hours later.

Among the University alumni practicing in the District of Columbia are:

Washington—Francis B. Bishop, class of 1883, 1913 I street N. W.; Edward M. Blackwell, class of 1890, Lieutenant-Commander, U. S. N., care Navy Department; Rupert Blue, class of 1892, Surgeon, U. S. P. H. and M. H. S.; Wm. Sinclair Bowen, class of 1888, Stoneleigh Court, Connecticut avenue and L street.; Albert Joseph Carrico, class of 1896, 2903 14th street N. W.; Francis Miles Chisholm, class of 1889, 1632 Rhode Island avenue N. W.; Horace Benjamin Coblenz, class of 1896, 1432 U street N. W.; George Robert Lee Cole, class of 1887, 418 7th street S. W.; George Wythe Cook, class of 1869, 3 Thomas Circle N. W.; Louis W. Crampton, class of 1869, Colonel M. C., U. S. A., care Adjutant-General's office; Frederick L. Darrow, class of 1910, interne Providence Hospital; Henry D. Fry, class of 1876, 1929 19th street N. W.; A. W. Valentine, class of 1904, 606 N. Carolina avenue S. E.

## THE TREATMENT OF ANEURISMS OF THE ARCH OF THE AORTA AND OF THE INNOMINATE ARTERY BY THE INTRODUCTION OF FOREIGN BODIES INTO THE SAC.

By REESE A. ALLGOOD, '12, Senior Medical Student.

We have had recently a very interesting case of aneurism of the transverse aorta in this hospital, which was treated with good temporary results by the Moore-Carradi method. This was a case of nine months' duration in a man 46 years of age.

This case belongs to the class of aneurisms with physical signs, for the tumor is easily recognized by inspection, although there are a few pressure symptoms present. For example, for about three weeks before the appearance of the tumor he had a constant cough; also he had some difficulty in breathing and swallowing. A few attempts have been made to induce coagulation of the blood in an aneurism by the permanent or temporary introduction of foreign bodies, such as wire, needles, horse hair, catgut, etc., into the sac. The method rests upon the well-known fact that if freshly drawn blood be whipped with a bundle of fine rods the fibrin collects upon them. The first case of permanent introduction of foreign bodies was that of Moore (1864); this was a large aneurism of the arch of the aorta which had destroyed part of the bony wall of the thorax and threatened to rupture the skin. He introduced through a fine cannula twenty-six feet of fine iron wire, moving the cannula about so as to coil the wire within the sac; coagulation promptly followed and pulsation ceased for a time, but inflammation set in, pulsation returned and the patient died on the fifth day.

On March 23, 1871, Dr. Dornville introduced 14 inches of fine iron wire into an aneurism of the aorta that projected through the sternum. The tumor became firmer, but continued to increase in size, and on April 9 he introduced nine needles each two and one-half inches long. Fatal hemorrhage occurred on the 23d. The needles and the wire were found in a dark fibrinous coagulum.

In April, 1872, Mr. Murray presented a patient to the Royal Medical and Chirurgical Society and



read an account of three other cases all treated by this method.

In the first case an aneurism of the aorta and innominate, eighteen or twenty needles were introduced and left in for 24 hours. Then 24 feet of wire were inserted. The patient had no symptoms, but died suddenly two weeks after the last attempt.

Case II. Aneurism of aorta. Needles were inserted at two different times, erysipelas began at the puncture and caused death.

Case III. Aneurism of aorta and innominate. Twenty feet of catgut were inserted, and at autopsy it was found softened with no coagula upon it.

Case IV. The one shown to the society was a sacular aneurism of the subclavian. Five or six trials of complete transfixion with 20 or 30 long needles for several hours were followed each time by consolidation, lessening of size and relief of pain.

Dr. Lewis introduced 24 feet of horse hair into an aneurism of the right subclavian afterwards without any beneficial result.

In January, 1879, Mr. Christopher Heath introduced three pairs of fine sewing needles, making each pair cross in an aneurism of the left subclavian artery. The needles were withdrawn on the fifth day and the tumor became solid. The patient died a few days later of bronchitis and the aneurism was found full of dense fibrins.

In 1890 McEwen's practice for inoperable aneurism consisted in the introduction of a long needle into the aneurism tumor, where it remained 24 hours, during which the needle was moved sufficient to scratch the intima and produce sufficient irritation to induce the formation of a white fibrin thrombus. This method is very uncertain.

In 1879 Carradi, like Moore, introduced into an aneurism 40 c. m. of wire, and then connected the extremity of the wire with the positive pole of a battery, the negative being applied to the neighborhood of the aneurism; he failed, and so did his immediate followers.

Hunner of this city, in a careful study and compilation of the reported cases treated by this method up to 1900, combining the statistics of the thoracic and abdominal cases, collected 14 cases in which Moore's method of wiring alone had been adopted. Of these 14 cases, 8 were thoracic and 6 were abdominal. Two of the ab-

dominal cases were apparently cured (14 per cent. recoveries.)

With the combined method (Moore-Carradi) there are 23 cases—17 thoracic and 6 abdominal. Four of these, or 17 per cent., recovered, including three thoracic and one abdominal.

Since Carradi introduced the combined method in 1879 great improvements in the technic have been made, especially by American and British surgeons, who have applied this treatment more often than those of other countries. The chief improvement lies in the better wire; the silver wire best not to exceed No. 28 gauge (0.0085 mil.) in diameter. Gold wire is preferred by Stewart of Philadelphia; silver blended with copper alloy is preferred by Finney and Hunner. Some use only 10 feet of wire, while others use 30 to 50 feet. Also the number of milliamperes varies, as Finney says he never uses more than 70, while Keen says he has used as much as 200 without appreciable bad effects.

D'Arcy Powers, 1903, improved the technic by utilizing an apparatus devised by G. H. Catt. This consists in a closely packed wire which is twisted through a fine canula previously introduced into the sac, where it expands, thereby insuring a better distribution of the wire network and reducing very greatly the time required to insert many inches of wire.

Case I. Name, T. P.; age, 46; occupation, laborer; married; complaint, a tumor in the neck.

Family history negative. Past history negative as to diseases having a bearing on his condition, with the exception of syphilis, although he positively denies having had syphilis. On March 3 a positive Wasserman was made, which probably is the etiological factor of the disease. The patient entered this hospital with a large pulsating, expansive tumor in and above the episternal notch.

The treatment was about as follows: He was at once put to bed and kept quiet for a few days; then an operation was performed by Professor Winslow. He was brought into the operating-room, the field of operation having been prepared for an aseptic operation while in the ward by painting the skin with equal parts of alcohol and tincture iodine. No anesthetic was used. A fine trocar was introduced into the sac and a silver wire was passed through this trocar into the cavity. Owing to the difficulty of passing the wire, only six feet were introduced, and with the needle still in the sac the galvanic current was

connected with the wire for ten minutes with a current of twenty milliamperes. The greater part of the wire curled up on the right side, and soon it was noticed that this side was firmer to touch than the left. Six days later another operation was performed similar to the first, with the exception that two pieces were used, the former sixteen feet long, the latter only four feet, and a current of 40 milliamperes was passed for 20 minutes through both separate pieces. Subsequently about 15 feet of wire was introduced, making about 40 feet altogether.

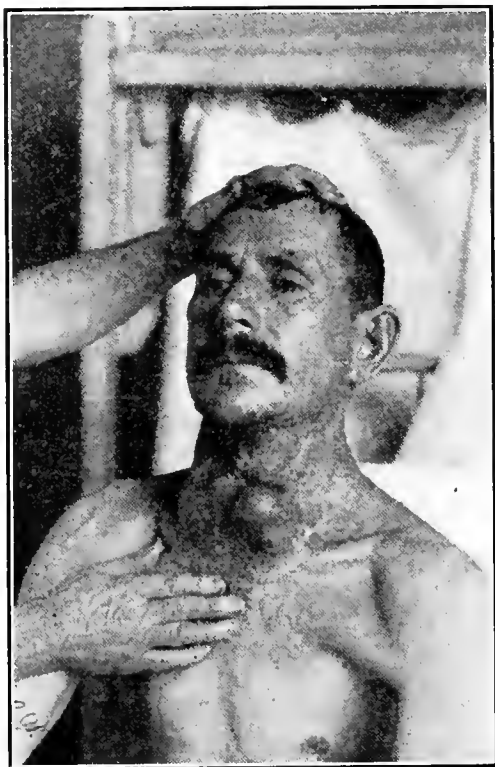


FIG. 1. CASE I.  
Aneurism of arch of aorta.—Dr. R. Winslow.

This operation gave the patient very little pain and was a great success, for instead of the pulsating expansive tumor we now had a tumor with very slight pulsations; and it is firm to touch, whereas before the operation it was very thin and soft and threatened to rupture. This treatment undoubtedly prolonged this patient's life, but he died in about three months of hemorrhage.

Case II. On January 2, 1912, Lillian Hallaway, age 38, entered the University Hospital, complaining of a swelling in median line of the chest. She first noticed this swelling about two years previous to entrance, but had pains in the



FIG. II. CASE I.  
Skilagram of aneurism of arch of the aorta, showing about 40 feet of silver wire.—Dr. R. Winslow.

chest six months before she first noticed the swelling. Physical examination shows a tremendous pulsating tumor of upper thorax, extending into neck. The pulsations are in all directions and (synchronously) with the heart beat. The manubrium and the five upper ribs near their costo-sternal margin are entirely eroded. The tumor extends up into the neck and has two marked projections, ear-like at the apex, marked pulsations over entire mass. Expansile walls are very thin.

Patient emaciated and unable to speak above a whisper, breathing labored.

*Family History:* Mother and father living and well; two sisters and five brothers all living and well. No history of rheumatism, tuberculosis, malignancy; no history of nervous trouble. Had two children born dead. No live children. No other history of lues.

*Past History:* Had whooping-cough when quite young. Negative to measles, mumps, diphtheria, scarlet fever and all other diseases of childhood. Negative to typhoid fever and pneumonia; had an attack of malaria several years ago, from which she fully recovered. Venereal history negative as regards gonorrhea. No sore throat, eruptions over body or hair falling out. No history of lues at all.



FIG. III. CASE II.  
Aneurism of arch of aorta protruding through chest wall.—  
Dr. R. Winslow.

*Habits:* Has not slept well for past several years. Drank beer moderately until about a year ago. Drinks one or two cups of coffee once a day; uses a great deal of snuff. Drinks five or six cups of tea a day.

*Menstrual History:* Her menses appeared at the age of 13; occur irregularly and last from four to ten days, with great pain. She saw her last period last September. The flow has always been very profuse at time of menstruation. She says that just before the period began there was a small "pimple" or "pustule" on labia, which suppurated and disappeared with period. These were noticed only during the last four or five years of her menstrual life, but did not appear every month. No abortions or miscarriages.

*Present Illness:* Last April she noticed a slight bulging in chest at about the middle of sternum, which gradually grew larger, extending upward.

There has been constant pain since about four months before she noticed the swelling. This pain is of a dull, stinging character over entire front and upper part of chest. She says that at every throb of her heart the pain is more intense.

There is considerable difficulty in speaking, and great pain when she speaks. There is also pain on swallowing; sometimes causes violent coughing spells.

*Alimentary Tract:* She has suffered for several years with vomiting spells. Says she doesn't remember the time, if before or after meals. The vomitus was of a greenish color and bitter taste. Says there was occasionally a trace of blood in the vomitus. Appetite has always been good. She says she often has indigestion. The pains are in the epigastric region. No great loss of weight. Says she would lose a few pounds, but would soon gain them back. Very often suffers from diarrheal attack in summer; has noticed some blood in stools.

*Pulmonary Tract:* No history of cough before the present illness. No bronchitis. Some hoarseness at present. No spitting of blood.

*Cardio Vascular System:* Some swelling of ankles before the present illness, which was transient. Negative to dyspnea, palpitation and all other symptoms connected with this tract, except the severe pains over the heart during the present illness.

*Nervous System:* When patient was 16 years of age she began suffering with epileptic fits, which occurred about two or three times a month until eight years ago, at which time she came here for treatment and was apparently cured. At the time of these "spells" she would become unconscious and fall immediately where she was at that time. The unconsciousness usually lasted about one hour. She says that two or three days before the attack she could tell they were coming on.

Notwithstanding the fact that she has a negative history to lues, she gave a positive Wasserman reaction. The X-Ray shows a large tumor mass filling upper chest, extending from heart into the neck. Erosion of the sternum and ribs and spinal vertebrae posteriorly to the tumor.

January 15, 1912, patient brought to the operating-room and the field of operation prepared for an aseptic operation by painting the surface with dilute tincture iodine; then a needle was introduced into the pulsating tumor and 36 feet of fine silver wire was introduced through the needle. The needle was then withdrawn and the wound closed with a collodion dressing. The patient was then removed to her bed in the ward, no worse off as a result of the operation.

Patient's breathing gradually got more labored, and on January 18 she died without any rupture of the aneurism having occurred.

## GASTRIC ULCER.

By NATHAN WINSLOW, M.D

During the past decade indurated ulcer of the stomach has passed from the domain of medicine into that of surgery. This has been brought about chiefly by the accidents secondary to ulcer; complications which are in themselves necessarily surgical. The investigations of the Mayos have definitely proven at least 60 per cent. of gastric cancer engrafted on an old ulcer base. As the large majority of ulcers of the stomach involve the lesser curvature immediately above the pylorus, the thickening resulting from the chronic inflammatory process may cause obstruction to the free passage of food into the intestines. The ulcerative area may extend through the entire thickness of stomach wall and set up either an acute localized or generalized peritonitis. Following the erosion of a vessel serious hemorrhage uncontrollable by medical means may endanger life. The last, but not the least important factor in compelling the shifting from the internist to the surgeon, was the realization that medicines do not give permanent relief. Therefore gastric ulcer as soon as recognized, and when the patient is in prime physical shape, should in every instance be referred by the doctor to the surgeon, else sooner or later some one of the above mishaps may ensue. To assure the patient the best prospects of cure and the return of health as in other surgical affections, the malady should be recognized earlier.

Heretofore, the lack of prompt recognition has accounted for the poor operative results, but today with a definite clinical picture there is no reason why these sufferers should not be brought to operation before the last stages of starvation, and thus be saved not only years of suffering, but, also, the possibility of death from cancer. The only case upon which I have been privileged to operate occurred in the service of Dr. Randolph Winslow at the University Hospital. The patient, a woman, with perforating ulcer of the stomach and peritonitis, died.

With this object-lesson before me; I desire to impress upon my readers the urgency of thoroughly acquainting themselves with the manifestations of ulcer of the stomach.

Ulcer of the stomach may be classified as indurated and non-indurated or mucous, or surgical

and non-surgical. The non-surgical ulcer gives rise to no definite symptomatology. It occurs as an erosion of the mucous membrane, from which blood seeps, and is practically impossible of detection, even after the stomach is opened. It is the indurated ulcer with which surgery is concerned, and as to all intents and purposes the portion of the duodenum, which is above the bile duct opening, is physiologically a portion of the stomach; what is said concerning ulcer of the stomach applies equally as well to duodenal ulcer. The first portion of the duodenum, at least that part above the common bile duct is developed from the foregut, and like the stomach is concerned with the preparation of food for digestion and takes no part in absorption. Indurated ulcer is essentially chronic, and involves not only the mucous membrane, but also some or all of the underlying tissues. In the stomach proper it occurs with about equal frequency in man and woman, but in the duodenum in the ratio of three in man to one in woman. It is generally solitary, but may be multiple. By far the majority are situated in or near the pylorus. Heretofore hyperchlorhydria has been insisted upon as a necessary accompaniment of ulcer. Later investigators, however, have determined that too much dependance cannot be placed upon the outcome of stomach analysis, as an ulcer is frequently present when there is an hypochlorhydria. Thus as in many other maladies experience teaches us to *place* more weight upon the existing clinical signs, rather than upon the results of the laboratory; not that the laboratory findings are not of value, which would be a mistake, but more as a confirmatory than as a negative aid. The symptomatology of ulcer of the stomach is characteristic. The patients complain of gastric disturbances which have extended over a period of many years. The periodicity of attacks of pain, coming on some three or four hours after meals, sour eructations, belching of gas, vomiting and hematemesis are typical. The pain is at its worst during the height of digestion, in order to alleviate which the patient soon learns to take more food, a glass of milk, or resorts to bicarbonate of soda or other mild alkalies, or induces vomiting. The pain, however, may occur on an empty stomach, and especially at night, as a consequence of which the patient places food near the bed to use as needed. In the beginning the patient eats large quantities of food, but as the disease progresses he obtains

more relief by munching more frequently smaller quantities. During the later stages there may be almost complete loss of appetite. Although pain is one of the most prominent symptoms, it must be distinctly borne in mind that it is not always present. Much emphasis was formerly placed upon the reference of pain to the left subscapular region, but this is not a reliable symptom. When present it is usually seated in the epigastrium, for ulcer of the stomach to the left, and of the duodenum to the right of the mid line. Vomiting may not exist until stenosis of the pylorus occurs, but there is always some gastric distress and eructation of sour, bitter, acrid, fluid or belching of sour gas. Great stress was formerly laid upon hematemesis, but this symptom may never occur, as the ulcer base is not covered with a granulation tissue, but is smooth and of a grayish color. Erosion of the teeth as a result of the action of the acid vomitus is not uncommon. Initially the nutrition is good, but as the disease progresses owing to the ingestion of insufficient quantities of food or retention in the stomach due to thickening of the pylorus, emaciation and even cachexia ensue. Constipation is a constant concomitant. In a few instances a tumor may be felt. If the ulcer be seated in the pyloric region, obstructive symptoms, through the deposit of inflammatory products, will arise, as a result of which there will be dilatation of the stomach and retention of food. The index of retention is the recovery of food eaten six or seven hours previously. Such an attack may last for days or weeks, to be followed by a period of relief, and sooner or later a remission. In the beginning the intermission between the attacks may be of some duration, but as the disease progresses the interval between is shorter, and the attack itself more prolonged.

A history of prolonged gastric disturbances and discomfort, pain arising four or five hours after meals, and relieved by the ingestion of food, bicarbonate of soda, milk, etc., periodicity of attacks after apparent cure, eructation of sour, acrid, bitter liquids, munching of food after retiring at night, recovery of blood from stomach contents with a high hydrochloric index is pathognomonic of ulcer of the stomach.

The question of treatment in gastric ulcer is intimately tied up with its complications. In perforating ulcer the opening may be closed by suture and drainage instituted. This is the simplest line of action and is especially applicable to

patients in bad condition. I followed this method in the above mentioned case.

If the patient's condition warrants the ulcer bearing area may be excised, or either of the above operations may be combined with gastro-enterostomy by the no-loop method. Gastro-enterostomy by itself oftentimes fails, and will inevitably do so unless there is pyloric obstruction. It has been proven when the pylorus is patent food instead of passing through the stomach-bowel opening will preferably follow the natural course. If the ulcer be situated in or near the pylorus and obstructs the passage of food gastro-enterostomy, when performed by the posterior no-loop method, gives excellent results. This is done preferably by suture. Owing, however, to the possibility of the development of cancer on the ulcer base some operators, and especially Rodman, practice and advise pylorotomy with gastro-enterostomy at place other than resection. Ulcers of the body and the lesser curvature should, if practical, be excised. Ulcer of the duodenum has not the same tendency to undergo malignant degeneration as ulcer of the stomach; therefore, there is not the urgent necessity of excision as in gastric ulcer. Here gastro-enterostomy is the usual line of procedure, but if the indications warrant the ulcer may be excised.

Mayo, in a series of 18 acute perforations operated by suture alone, and states that only one required a secondary gastro-jejunostomy, the perforation having seemingly put an end to the disease. Acting upon the observation he has twice, in chronic gastric ulcers where the conditions were such that he could not excise and where gastro-enterostomy was not indicated, exposed the crater of the ulcer, thus producing the picture of an acute perforation, then closed the defect with a favorable outcome. In the early days of ulcer surgery pyloroplasty was a favorite method of overcoming the obstruction, but was followed by so many relapses requiring secondary operations that it has been to a large extent abandoned. The operative technic of gastric and duodenal ulcer has reached such a point that the mortality is negligible and may be summed up as follows: Ulcers to the left of the pylorus are excised; in the pylorus either a pylorotomy or no-loop gastro-enterostomy is chosen; in case of perforation the opening may be sutured or better the involved area excised—abdominal drainage being instituted, no matter which is employed;

gastro-jejunostomy answers well for duodenal ulceration.

In conclusion, I desire to emphasize the importance of early exploratory operation in stomach affections, producing invalidism. There should be no conflict between medicine and surgery in this field. If after a reasonable length of medical treatment the symptoms remain unabated, surgery should be called in as a diagnostic and possibly therapeutic measure.

### DROP FINGER, WITH REPORT OF CASE.

By NATHAN WINSLOW, M.D., Baltimore, Md.

The finger is heir to many injuries, some of which are common, others less frequently seen. Amongst the rarer injuries is the condition known as drop or mallet finger. Not having seen such a condition until recently, the writer believed it of sufficient interest to bring to the attention of the readers of *THE BULLETIN*, so that when dealing with finger injuries they may bear in mind its possibility. As the name implies, there is a dropping of the terminal phalanx of the finger, as a result of either complete or partial rupture of the extensor tendon near its insertion, following a blow to the tip of the extended finger causing forcible flexion. The deformity may be merely a slight dropping or the bending may be as much as a right angle.

In recent cases the finger should be extended and a splint applied after thoroughly padding the parts. The splint should include not only the finger, but also the wrist of the affected hand, so as to thoroughly relax the tendon and thus favor union. If this procedure proves ineffectual, the tendon should be exposed by an incision, and the torn end sutured into the periosteum of the base of the terminal phalanx; and the finger and wrist immobilized as recommended above.

#### CASE.

Mrs. M. consulted me during the early part of November (1911) about an injury she had sustained to the middle finger of her right hand which she had incurred by striking the tip against a board a few weeks previously. The blow was so severe that the finger felt numb, and on examination she noticed the end phalanx flexed and

voluntary extension impossible. She was able, however, to straighten the finger with the aid of her other hand, but the deformity recurred as soon as the support was released. When I saw the patient the deformity was typical of the condition, and the diagnosis readily made upon the receipt of the history of the accident. Splintage in extension was ordered, and immobilization was maintained for six weeks. Though the finger is still somewhat swollen and at times painful, it is functionally perfect, voluntary extension and flexion being almost normal.

The following have received appointments as clinical assistants at the University Hospital for 1912-1913:

S. A. Alexander, North Carolina.  
John T. Beavers, North Carolina.  
B. Karl Blalock, North Carolina.  
Earle G. Breeding, Maryland.  
J. M. Buch, Cuba.  
Humphrey Butler, Maryland.  
Leo M. Cavanaugh, Maryland.  
Vernon H. Condon, Maryland.  
Frederick L. Detrick, Virginia.  
Idalberto Fajardo, Cuba.  
Leonard Hays, Maryland.  
Howard E. Lecates, Maryland.  
Elmer Newcomer, Maryland.  
Norbert C. Nitsche, Maryland.  
Walter A. Ostendorf, Maryland.  
Harry C. Raysor, South Carolina.  
William Henry Scruggs, Jr., Georgia.  
Hamilton J. Slusher, Virginia.  
W. Houston Toulson, Maryland.  
Moody R. Troxler, North Carolina.  
Grady B. Wells, South Carolina.  
Cleveland D. Wheelchel, Georgia.  
Thomson B. Woods, South Carolina.

Among the University alumni practicing in Maine are:

Hebron—Ralph Norvel Knowles, class of 1909.  
Lewiston—Jos. Wm. Scannell, class of 1906,  
471 Main street.  
Machias—Harry Otis Johnson, class of 1903.  
Rumford—Louis M. Pastor, class of 1906.  
Washburn—Fay Frederick Larrabee, class of 1906.  
Winterport—Wm. A. Ellingwood, class of 1908.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, SEPTEMBER 15, 1912.

PROF. JULIAN J. CHISOLM AND MISS  
HELEN KELLER.

It will be a source of gratification, as well perhaps as a great surprise, to learn that Professor Chisolm was connected in any way with the wonderful case of Helen Keller, or to put it more correctly, the case of the wonderful Helen Keller. Blind, deaf and dumb, without the light of the day and almost without that of the mind, she has become one of the most highly educated woman in the world. She can speak not only English fluently, but French and German also; she can read Latin and Greek and is conversant with many other branches of learning. In an address before the Congress of Otiologists, held in Boston recently, she gives Dr. Chisolm the credit for advice that led to her restoration to society as a useful and highly intelligent integer. It gives us pleasure to reproduce the following extract from the *Baltimore Sun*:

CHISOLM AND HELEN KELLER

Baltimore Specialist Suggested Her Education.

[From the speech by Helen Keller to the Otiologists' Congress in Boston.]

"I was about six years old before any of the specialists whom my parents consulted was brave enough to tell them that I should never see or hear. It was Dr. Chisolm of Baltimore who told them my true condition. 'But,' said he, 'she can be educated,' and he advised my father to take

me to Washington and consult Dr. Alexander Graham Bell as to the best method of having me taught.

"Dr. Chisolm did exactly the right thing. My father followed his advice at once, and within a month I had a teacher, and my education was begun. From that intelligent doctor's office I passed from darkness to light, from isolation to friendship, companionship, knowledge. The parent who brings his child to your office, to your hospitals, should find in you, not a teacher, perhaps, but one who understands how far it is possible to right the disaster of deafness."

Dr. Chisolm was not only a great ornament to the University of Maryland, and a teacher of great force and erudition, but he was also a very prominent citizen. He retired from teaching in 1894 and died in 1903.

COMBINING THE MEDICAL SCHOOLS  
OF BALTIMORE.

Medical education in this country is in a state of rapid evolution, and is at this time in a transitional condition. On the one hand we have some of the State universities and the highly endowed private schools, demanding qualifications that are almost impossible of attainment. On the other hand there are many schools of very low grade that bring disrepute on the medical profession. There are also other institutions that do not maintain the most advanced standards, that are nevertheless doing as useful work as the first mentioned class, but of a somewhat different character. If an institution is so well endowed that it can demand that all candidates for admission shall have academic degrees, it is its right to do so, and it ensures a highly desirable class of students. It does not seem proper, however, that the profession of medicine shall be an aristocracy rather than a democracy, and there must be schools where those whose circumstances of one kind or another have prevented their obtaining a college education, may nevertheless secure a medical training.

It is a question as to the desirability and propriety of exacting such high standards, and certainly at this time but few colleges can do so. The Baltimore medical schools belong to this middle class, that give excellent training in medicine, but only require a completed four years high school course for admission. There are



too many medical colleges in this country, and an effort is being made to reduce the number and to improve those that remain. The suggestion has come from many sources, to merge the three larger schools here, and to form one school, better equipped and better financed than the three separate schools.

It is with pleasure that we notice an interest in this matter aroused in this city, as the following editorial from the *Baltimore Sun* of August 28, 1912, indicates:

#### COMBINING THE MEDICAL SCHOOLS.

"If the University of Maryland, the College of Physicians and Surgeons and the Baltimore Medical College can be consolidated, and the combined endowment funds used to create a medical school of the very highest rank, it would be a desirable thing.

"Doubtless there would be many incidental difficulties in the way, but the men capable of guiding a great medical school ought to be capable of surmounting these difficulties.

"Of course, any consolidation of the kind must retain the historic and honored name of the University of Maryland, an institution which has done so well with the comparatively meager funds it has had at its disposal as to give assurance of yet better service if it should ever become possessed of an ample purse."

This desirable result can be easily accomplished if the citizens of this city will come to the aid of the medical schools. The citizens of Baltimore have been very liberal to another university, and we now appeal to them to help us to form and maintain another high-grade medical school here.

#### KEEP A-PULLIN'.

When you've got a thing to say, say it. Some people have something to say, others make a lot of noise, but say nothing. The University of Maryland is passing through a transition. The opportunity for broader efforts is within her grasp. At no time in her history has she been in such a maelstrom of unrest. Nobody knows what tomorrow will bring forth. Surprises are the order of the day. Progress is the rally call. The daily papers are giving us kindly notices and are bringing our needs to the attention of the public. We need it all; but, alumni, we need above all your kindly advice and sympathy. As-

sist us by your counsel, and exert whatever influence you may possess with the several faculties for the appointment of a paid head of the institution. THE BULLETIN desires to sound your sentiment in this matter. Its pages are at your disposal. But come what may—always keep a-pull-in' for a better day.

#### THE PATHOLOGICAL ENDOWMENT FUND.

The chairman of the endowment committee has been away on a vacation, and everybody else has been away. The heat and humidity have been equal to that of the Canal Zone, and the dog days have been unusually oppressive. No efforts have been put forth to add materially to the pathological fund, and nobody has surprised us by insisting on giving a large donation to the fund. We cannot report, therefore, any great increase, but are thankful for the little that has occurred.

#### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	70 00
1873.....	430 00
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	50 00
1900.....	215 00



1901.....	240 00
1902.....	305 00
1903.....	315 00
1904.....	145 00
1905.....	210 00
1906.....	165 00
1907.....	110 00
1908.....	20 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to Sept. 1, 1912, \$10,181 50

#### NEW SUBSCRIPTIONS IN AUGUST.

Dr. L. W. Talbott, 1883.....	\$5 00
Dr. B. F. Bussey, 1884.....	40 00
Total .....	\$45 00

### ITEMS

Dr. Charles Wesley Gardiner, class of 1901, is located at 449 State street, Bridgeport, Conn.

We are in receipt of the following letter from Dr. Love, and are glad to "pass it on" to our alumni:

September 10, 1912.

*Nathan Winslow, M.D.:*

My Dear Doctor—In reply to your request for the treatment of tetanus as used in the Franklin Square Hospital, will state that for the past five or six years we have been using the Bacilli method, which is the administering hypodermically of carbolic acid. I generally order a 2 per cent. solution of carbolic acid:

R Acid carbolici 5  
Aq. distillat 245

Of this I give hypodermically 30 m. (1.84 c.c.) containing acid. carbol. gr. 3/5 (.0387 gm.) every three hours, and gradually increase the dosage or shorten the interval until patient gets from grs. viii to xv (0.5 to 1. gm.) daily.

There is no selective point for the injection.

With this as curative treatment we try to control convulsions with chloral, chloretone, bromides or morphia in suitable doses. During the administration of carbolic acid the urine is examined daily.

Enemas of normal salt solution given daily.

There have been nine cases of tetanus treated at the Franklin Square Hospital during the past seven years, with one death, and this case received serum treatment, but no carbolic acid. Three cases received each one injection of serum and the Bacilli treatment. Five cases received the carbolic acid treatment only.

I believe Dr. P. Kintzing treated the larger number of these cases besides several other cases in his private practice. Naturally we first disinfect the wound.

Very truly yours,

WILLIAM S. LOVE,

Class of 1890.

Dr. Benjamin Newhouse, class of 1912, who was for a time resident pathologist at the Hebrew Hospital, is now resident surgeon in the Emergency Hospital, Washington, D. C. In his examinations before the State Board in Maryland Dr. Newhouse received 100 in surgery and 97 in obstetrics.

Dr. Nathan Winslow, class of 1901, left on the 11th for a trip to St. Augustine and Jacksonville, Fla.

Dr. John C. Hemmeter, in the Baltimore *Evening Sun* of July 18, has the following to say concerning the report on the medical schools made by Abraham Flexner to the Carnegie Foundation:

"To do justice to the past and present state of the systems of medical education in this country, we must take into consideration the political environment under which they were created. At a period in the history of our people when the State was incapable or unwilling to provide for financial support of secondary schools and universities, there was no other way of securing the institutions and teachers except by private undertakings. Naturally, this method of organizing medical schools was abused, and in many cities these so-called colleges were started for egotistical purposes, exclusively, not really to advance either medical discipline or science, and Dr. Pritchett is right in condemning such schools. He and Flexner may be pardoned for being too sweeping in their otherwise laudable and correct generalizations.

"To understand the European professional education one must appreciate what Dr. Pritchett and Mr. Flexner admit, namely, that it is based on an exceptionally high level of secondary school

discipline in Germany. A standard of this kind has not yet been attained in America.

"Dr. Pritchett states that a system of education is to be judged not by its occasional brilliant successes, but by the general level of performances of those whom it undertakes to train. Exactly so, and judged by that method the University of Maryland is an institution of learning that need not be ashamed of its record, for among its alumni today are professors in our largest and most richly endowed American universities. It has produced such men as William T. Councilman, professor of pathology at Harvard University; Homer Wright, professor of pathology, Harvard Medical School; Alexander C. Abbott, professor of bacteriology, University of Pennsylvania; William T. Howard, professor of pathology, Western Reserve University; Major James Carroll, discoverer of the transmission of yellow fever by the bite of a specific mosquito.

"In addition to these men, I might mention Gen. Rupert Lee Blue, the present Supervising Surgeon-General of the United States Marine Hospital Service, and also Dr. Henry R. Carter, who first announced and discovered the so-called extrinsic method of incubation of the yellow fever infective agent.

"When an institution like the University of Maryland turns out so many original discoverers and brilliant thinkers this could not possibly be accidental, as Dr. Pritchett would suggest when he states that 'a poor school may from time to time bring forth great practitioners.' In the same manner some are inclined to assign the brilliant work of our alumni not to the training of inspiring teachers who are competent masters of the subjects they teach in the University of Maryland, but they fictitiously assign their brilliancy to laboratories and other universities in which some of our alumni took short post-graduate courses. If this were applied to the very universities that Dr. Pritchett lauds in this manner, these institutions would be robbed of the credit of having trained and developed some of the best minds among their alumni. For, upon investigation, it is found that the alumni of Harvard, Yale and Johns Hopkins have taken post-graduate courses in Germany, Austria, England and France.

"It is not the short post-graduate course, which rarely exceeds one year, that develops the great thinker and research worker, but the constant,

enduring guidance of the professor who conducts his pupil for several years, beginning with the very first instruction he ever receives in medicine.

"In the Johns Hopkins University itself the dean of the Department of Medicine, both professors of ophthalmology, the professor of psychiatry and the professor of neurology are alumni of the University of Maryland.

"On page 289 of the report Dr. Abraham Flexner gives some interesting statistics of the money spent in five German universities for professional salaries, the number of their assistants, the cost thereof, the number of servants and the laboratory expense. I can judge only of my department at the University of Maryland and can say that the professor of physiology receives more salary at the University of Maryland than is devoted to that purpose at Berlin, Leipzig, Konigsberg, Griefswald or Giessen. That he has three paid assistants, which number is exceeded only by the University of Berlin, and that our laboratory expenses are greater than those of Konigsberg, Griefswald or Giessen. The reason why Berlin and Leipzig spend more for assistants and laboratory expenses than the University of Maryland does is due to the fact that they teach four times as many students.

"The entire volume written by Dr. Flexner on Medical Education in Europe represents the most scholarly and comprehensive contribution to this subject ever published in America."

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The following alumni have been appointed to positions in the City Health Department:

Health Warden, Thirteenth Ward, Dr. John Henry Von Dreele, class of 1910, succeeding Dr. Vernon F. Kelly, class of 1904; salary, \$900 per annum.

Health Warden, Fourteenth Ward, Dr. Edwin Kemp Bartlett, class of 1887, succeeding Dr. William Caspari; salary, \$900.

Dr. Marshall G. Smith, class of 1887, has retired as Health Warden of the Nineteenth Ward.

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Dr. Arthur Dean Bevan of Chicago, a director of the American Medical Association, will be the guest of Prof. Randolph Winslow during the month of September, and will take an active interest in the proposed merging of the Baltimore

Medical College and the College of Physicians and Surgeons with the University of Maryland.

Dr. John J. R. Krozer, class of 1848, and nestor of the University alumni in Baltimore, took an automobile ride for the first time in his life on September 4. Dr. Krozer rode but four squares, and it took some persuasion to induce him to enter the car. Dr. John C. Harris, class of 1862, was with him. Dr. Krozer is 85 years of age, and says he prefers a horse and buggy any day to the machine.

Dr. Charles A. Hollingsworth, class of 1881, has been appointed postmaster of Belair, Md. Dr. Hollingsworth has been a practicing physician in Belair for over 30 years. He is 55 years of age. He married a Miss Young, daughter of the late Colonel Young, and has four sons and a daughter. He received notification of his appointment by a telephone message from the First Assistant Postmaster-General.

Dr. Thomas Chew Worthington, class of 1876, spent the summer at his country place in Baltimore county.

Dr. Eugene Bascom Wright, class of 1909, resident physician at the Church Home and Infirmary since September 2, 1911, has succeeded Dr. Chadbourne Andrews as resident physician of the Hebrew Hospital.

Dr. Walter H. Mayhew, class of 1901, is an assistant resident physician at the Maryland Tuberculosis Sanitarium, at State Sanatorium, Md.

Dr. William J. Coleman, class of 1908, has been reappointed superintendent of the University Hospital for the coming year.

Dr. Charles A. Waters, class of 1911, is on the X-ray staff of the Johns Hopkins University. It gives us pleasure to announce to his friends that he is making good in his chosen line.

The residence of Dr. August Horn, class of 1888, 40 E. 25th street, Baltimore, suffered slight damage by being struck by lightning during a heavy rainstorm in August. The chimney was struck and a number of bricks thrown into the street. The current then ran from the chimney

down the metal cornice of the adjoining house in the form of a ball of fire, jumped to an unused wire, dropped a few sparks and disappeared.

The following University alumni are members of the faculty of the College of Physicians and Surgeons, Baltimore:

Charles F. Bevan, M.D., class of 1871, professor of principles and practice of surgery, clinical and genito-urinary surgery.

George W. Dobbin, A.M., M.D., class of 1894, professor of obstetrics and gynecology.

William Royal Stokes, M.D., Sc.D., class of 1891, professor of pathology and bacteriology.

Archibald C. Harrison, M.D., Class of 1887, professor of anatomy and clinical surgery.

Cary B. Gamble, Jr., A.M., M.D., class of 1887, professor of clinical medicine.

Charles E. Simon, A.B., M.D., class of 1890, professor of clinical pathology and experimental medicine.

Anton G. Rytina, M.D., class of 1905, associate in genito-urinary surgery.

Francis W. Janney, M.D., class of 1905, associate in ophthalmology and otology.

William T. Watson, M.D., class of 1891, associate in medicine.

S. Griffith Davis, M.D., class of 1893, lecturer on anesthetics and assistant demonstrator of anatomy.

W. Milton Lewis, M.D., class of 1888, assistant in clinical laboratory.

Joseph L. Kemler, M.D., class of 1907, assistant in ophthalmology and otology.

Drs. Archibald C. Harrison, class of 1887; George W. Dobbin, class of 1894; Cary B. Gamble, class of 1887; William T. Watson, class of 1891, and William Royal Stokes, class of 1891, are on the visiting staff of the Mercy Hospital.

Dr. George W. Dobbin, class of 1894, is one of the visiting obstetricians to the Maternite Hospital of the Mercy Hospital.

Among the admitting physicians to the State Sanatorium are Drs. Robert S. Page, class of 1898, Belair, Md.; Guy Steele, class of 1897, Cambridge, Md.; James McFaddin Dick, class of 1895, Salisbury, Md.; Louis Bernard Henkel, Jr., class of 1903, Annapolis, Md.; Henry Maynadier Fitzhugh, class of 1897, Westminster, Md., and

Guy Walter Latimer, class of 1901, Hyattsville, Md. Dr. Guy Steele is also a member of the board of directors.

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Dr. William B. Fellers, class of 1910, is located at 12½ Campbell avenue S. W., Roanoke, Va.

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Dr. Benjamin F. Carpenter, class of 1899, of Belton, S. C., was a recent visitor to the University Hospital.

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At the last meeting of the Alumni Athletic Association it was decided to support football, baseball and basket-ball during the coming season. Drs. Mitchell, Todd and Bay were appointed a committee to arrange for a track meet in the early fall. Dr. R. G. Willse has consented to act as coach for the football team during the season.

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Dr. Russell Hardy Dean, Jr., class of 1912, is practicing with his father in Jacksonville, Fla. Their office is located at Monroe and Cedar streets.

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The six full-time teachers in the University of Maryland for the season of 1912-13 will be Drs. I. M. Macks (pathology), J. Holmes Smith (anatomy), R. Dorsey Coale (dean, chemistry), T. L. Patterson (physiology and biology), H. J. Maddies (histology and embryology), and a sixth to be appointed.

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The following alumni are members of the dispensary staff of the Mercy Hospital: W. Milton Lewis, M.D., class of 1888 (skin diseases); F. W. Janney, M.D., class of 1905, Joseph I. Kemler, M.D., class of 1907 (diseases of eye and ear), and Anton George Rytina, class of 1905 (genito-urinary surgery).

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The staff of the University of Maryland Maternity Hospital for 1912-13 is as follows:

Prof. L. E. Neale, M. D., director, class of 1881.

Drs. L. H. Douglas, class of 1911; John D. Darby, class of 1912, and William Michel, class of 1912, resident physicians.

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Among the University alumni practicing in Georgia are:

Albany—John Cox Keaton, class of 1907.

Atlanta—Edgar G. Ballenger, class of 1901,

Atlanta National Bank Building; William Zellars Holliday, class of 1882, The Grand Building; Herbert Jerome Rosenberg, class of 1908, Grant Building.

Baxley—P. H. Comas, class of 1882.

Brunswick—Julian P. Harrell, class of 1906, 502½ Gloucester street.

Byronville—Edgar B. Watts, class of 1904.

Cedartown—Wm. Allen Chapman, class of 1887.

Dalton—Harlan L. Erwin, class of 1904.

Davisboro—Wm. Benj. Warthen, class of 1905.

Donaldsonville—Nathaniel L. Spengler, class of 1903.

Douglas—Charles Wesley Roberts, class of 1906.

Dudley—Josiah B. Walker, class of 1890.

Fitzgerald—Edwin J. Dorminy, class of 1890.

Gainesville—Henry Latimer Rudolph, class of 1902.

Graymont—Rufus Cecil Franklin, class of 1907; Virgil E. Franklin, class of 1896.

Harrison—Elijah S. Peacock, class of 1891.

La Grange—U. R. Allen, class of 1882, R. F. D. No. 5.

Louisville—Samuel T. R. Revell, class of 1905; Jefferson D. Wright, class of 1882.

Macon—Thomas E. Clackshear, class of 1894, Grand Building; Jos. W. De Guid, class of 1893, 572½ Cherry street; Weems R. Winchester, class of 1874, 610 Mulberry street.

Manchester—Herbert Melvin Foster, class of 1910.

Marietta—J. D. Malone, class of 1884.

Mt. Vernon—Charles Hicks, class of 1877.

Osierfield—Redding Hamilton Pate, class of 1898.

Quitman—Samuel S. Gaulden, class of 1886.

Reidsville—Orlando L. Alexander, class of 1875.

Rochelle—J. A. Bussell, class of 1888; Charles D. McRae, class of 1888.

Sandersville—George Skinner McCarty, class of 1905; William Rawlings, class of 1875; Oscar L. Rogers, class of 1897.

Savannah—Craig Barrow, class of 1900, 26 Liberty street, East; Julian Ford Chisolm, class of 1900, 6 E. Liberty street; Benjamin Harrison Gibson, class of 1909, 14 W. Liberty street; Raymond V. Harris, class of 1907, 118 E. Park avenue; John Smallbrook Howkins, class of 1897, 18

E. Liberty street; Everett Iseman, class of 1909, 11 E. Jones street; Bartolo Pedro Oliveros, class of 1883, 26 W. Harris street; S. Latimer Phillips, class of 1885, 232 Bull street; Harry Young Righton, class of 1907, 101 E. Walberg street; Marion Russell Thomas, class of 1902, 204 E. Ogleshorpe street.

Statesboro—Lehman W. Williams, class of 1909.

Stilson—Henry Newton King, class of 1910.

Thomasville—Harry Ainsworth, class of 1901.

Wadley—Ralph Leland Taylor, class of 1911.

Warthen—E. T. May, class of 1885.

Waycross—Richard C. Dodson, class of 1911.

Dr. J. Whitridge Williams, class of 1888, has returned from a trip abroad, and is at his cottage at Watch Hill, R. I.

Dr. John R. Winslow, class of 1888, spent the month of August at Gloucester, Mass.

Dr. Charles S. Woodruff, class of 1891, is spending several months at Port Dalhousie, Ontario, Canada.

Dr. John Turner, class of 1892, has returned from a visit to New York, from which city he motored through Connecticut.

The following letter has been received from Dr. Russell H. Dean, class of 1912:

"Dear Dr. Winslow:

"A line from Florida to cool you off. As hot as it is, it cannot touch Baltimore last year, but it does not miss it far. I am writing to impose some trouble on you. I am enclosing a check for two bones. Please put half to the Alumni Association and tack the other on the subscription list of the HOSPITAL BULLETIN, and pardon my delay in sending the former.

"I can't complain of overwork, but have got together enough to get this writing paper. Have given six anesthetics and removed two adenoids; the rest has been of the  $K\text{NmO}_4$  variety (3). Not exactly setting the world afire, but I could not see my way clear to the ball game this morning. I am enjoying it, as I have no board to pay yet, for if I did I expect I would have an awful uneeda and sardine appetite.

"Hope to see you this November at the conven-

tion. I am planning to get there, and may take the board if it is convenient—as Florida board is November 11, 1912—I may be able to get there in time.

"Hope you have that auto now.

"Kindest regards to yourself and all, including your father.

Fraternally,

"R. H. DEAN, JR."

Dr. Albert H. Carroll has returned from a trip to the United States Fisheries Laboratories at Woods Hole, Mass.

Dr. Roscoe D. McMillan, class of 1910, of Red Springs, N. C., will present a paper before the next meeting of the Atlantic Coast Line Surgeons, to be held in Richmond. The title of his paper will be "First Aid to the Injured, with Special Reference to Shock." This paper will appear later in THE BULLETIN.

Dr. Nathan R. Gorter, class of 1879, spent part of the summer in a camp in Canada with Dr. Thomas S. Cullen.

Dr. Perry Carman, class of 1901, has been visiting in Atlantic City.

Dr. Arnold Dwight Tuttle, class of 1906, First Lieutenant Marine Corps, U. S. A., at present surgeon at the Presidio, San Francisco, ran a losing race with death last week, when he raced across the continent to be with his father, Staff Quartermaster Sergeant Dwight S. Tuttle, who died three days before Dr. Tuttle reached Baltimore. Sergeant Tuttle is survived by his wife, two sons, Dr. Tuttle and Amos Tuttle, and three daughters, Mrs. John G. Lang and Misses Olive and Leslie Tuttle of Baltimore.

Dr. Walter S. Carswell, class of 1895, occupied his cottage at Ocean City during August.

Dr. Austin F. Robinson, class of 1903, spent the month of August on the Maine coast.

At the fourteenth annual meeting of the American Proctologic Society, held in Atlantic City June 3 and 4, 1912, Dr. Samuel T. Earle, class of 1870, of Baltimore, reported a case of primary tubercular ulceration of the right buttocks, which

was not connected with the rectum by a fistulous tract. In this respect it differed from the one reported by him in his work on "Diseases of the Anus, Rectum and Sigmoid," Fig. 62, page 201. It was excised by the thermo-cautery knife, after which it healed very promptly.

Dr. Earle also reported a very aggravated case of pruritus ani, which had resisted local applications, autogenous vaccines and treatment by the X-ray. Under local anesthesia he found an ulcer over the posterior commissure just above the internal sphincter, which connected on each side with numerous submucous and subcutaneous superficial fistulae which enveloped the entire anal margin and connected with each crypt of Morgagni. The ulcer was incised, the scar tissue at its base removed, and the fistulous tracts were all opened up. There was only an occasional twinge of itching following the operation, and he made a speedy recovery.

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Dr. J. Fred Adams, class of 1894, is at his country home at Catonsville for the early autumn.

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Dr. Charles C. Harris, class of 1883, of Cathedral street, spent early August in Atlantic City.

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Dr. John G. Jay, class of 1871, spent part of August in Quebec and points along the Sagueway river.

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Dr. Cary B. Gamble, class of 1887, recently made a canoe trip from Biddeford Pool to Megantic, Maine.

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Dr. John McMullen, class of 1895, passed assistant surgeon Public Health Service, has received notification that he has passed the examinations for promotion to the rank of surgeon. Dr. McMullen has done considerable research work in diseases affecting immigrants.

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Dr. Charles W. Mitchell, class of 1881, read a paper on the feeding of infants at the July meeting of the Baltimore County Medical Association.

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Dr. C. Urban Smith, class of 1889, spent the summer on the Severn.

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It is reported that Mrs. J. B. Thomas will equip a lecture hall at the Dental School of the Univer-

sity of Maryland as a memorial to her father, Dr. James Howell Harris, who died September 12, 1910. The room will be known as Harris Hall. Dr. Harris was connected with the school from the time it was organized until the time of his death. The bronze bust of Dr. Harris, which was presented to the school by the senior class, will be placed in this hall.

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Dr. Robert Garrett, class of 1890, assistant superintendent of the Maryland Hospital for the Insane, has been visiting in Atlantic City.

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Dr. Isaac C. Dickson, class of 1897, who has been very ill with appendicitis, is now on the way to recovery.

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Dr. Howard J. Maldeis, class of 1903, is in receipt of the following letter from Mr. Alberto Garcia de Quevedo, of the second year class, of Mayaguez, Porto Rico:

"Dear Dr. Maldeis:

"It was my idea to write you ever since I came down home, but thinking I was going to use some of your always busy time, I hesitated in doing so, but I do it now with the greatest pleasure.

"Our island was visited a few months ago by bubonic plague, and had it not been for the activity of the sanitation department of the island it would have been a serious matter, but, fortunately, everything is all right now. The people were greatly alarmed, but gradually came back to their nerves again.

"A few days ago I looked by the scope the Bacillus Pestis. I help my brother a little in his laboratory, and have had some bacteriological laboratory experience this summer.

"My brother sends his regards to you, and

"I am, sincerely,

"A. G. DE QUEVEDO."

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Dr. Alexander D. McConachie, class of 1890, spent the week ends of July at Buena Vista and the month of August on a motor trip through the North.

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Dr. Gordon Wilson, Professor of Clinical Medicine, spent the month of August in Newport and York Harbor.

The Baltimore *Notes* contains the following item concerning Dr. Marshall Langton Price, class of 1902:

"Dr. Marshall L. Price, secretary of the State Board of Health, has been appointed a member of the committee to represent the American Medical Association at the joint conference to be held at the Willard Hotel, Washington, September 18-20, to consider changes or modifications in the present model law for the registration of vital statistics.

"Besides the American Medical Association, other organizations to take part in the conference are the American Bar Association, the American Public Health Association and the conference of Commissioners on Uniform State Laws. The International Congress on Hygiene and Demography will be held in Washington the following Monday, and it is thought that many who will be present for the one event will also attend the other.

"Those on the committee with Dr. Price, who is the sole Baltimore representative, are Dr. J. M. McCormick, secretary of the State Board of Health, Bowling Green, Ky., and Dr. William C. Woodward, health officer of the District of Columbia."

Dr. Clarence W. Heffinger, class of 1881, of Sykesville, Md., is visiting in Murray Hill, Annapolis.

Among the University alumni practicing in Indiana are:

Camden—Chas. Edward Scholl, class of 1873.

Gary—James Alexander Craig, class of 1908, 652 Broadway.

Hagerstown—Chas. I. S. Stotemyer, class of 1892.

Indianapolis—Wm. R. Mayo, class of 1890, 715 N. Alabama street; Jos. W. Ricketts, class of 1909, Central avenue and 32d street.

Jamestown—Thomas B. Johnson, class of 1906.

Logansport—John Henry Reed, class of 1885, 416½ Broadway.

Philadelphia—John S. Bell, class of 1884.

Rockport—Arthur White, class of 1854.

Seymour—Grayson R. Gaver, class of 1898.

Dr. Joseph T. Smith, class of 1872, of The Cecil, is at Eaglesmere, Pa., for several weeks.

Dr. J. William Ebert, class of 1912, of Luther-ville, Md., has been visiting in Winchester, Va.

Dr. John C. Hemmeter, class of 1884, spent the month of August in North East Harbor, Maine, as the guest of Dr. Thomas E. Satterthwaite of New York.

Dr. St. Clair Spruill, class of 1890, is spending a vacation on the Magothy river.

## MARRIAGES

Dr. Maurice Eubanks Broadas Owens, class of 1910, was married on September 1, 1912, to Miss Maysville Jane Freeman, daughter of Mrs. M. W. Freeman, 845 W. Fayette street. Miss Freeman left Baltimore August 25 and reached Spokane, Wash., September 1. The ceremony was performed there at the residence of Dr. A. Aldridge Matthews, class of 1900, and brother of Dr. James G. Matthews, class of 1905. Dr. Owens is located at Long Lake, about 30 miles from Spokane, and he and Mrs. Owens went there immediately after their wedding.

Mrs. Owens is a graduate of the University of Maryland, department of pharmacy, of the class of 1907, and stood third in her class. Dr. Owens was then a student in the medical school, and graduated in 1910, winning the gold medal. He then served for a year in the University Hospital, leaving there to go to the State of Washington. He is a South Carolinian by birth. Mrs. Owens is a Virginian. She is also a graduate of the Shaftsbury College of Expression, and was principal of the Shakespeare College of Expression.

## DEATHS

Abel Huston Thayer, class of 1876, died at his home in Grafton, W. Va., September 8, 1912.

Dr. Thayer was born in Garrett county, Maryland, August 25, 1842, the son of Stephen and Rebecca (McCleary) Thayer, and was descended from American Revolutionary ancestors.

He began the study of medicine at Winchester Medical College, which was burned during the Civil War. He served as surgeon of the Sixth West Virginia Cavalry, U. S. V., during the entire war, serving with the Army of the Potomac and with Sheridan in the Valley of Virginia, and was a member of the West Virginia Constitutional Convention of 1872. He then entered the

University of Maryland, graduating in 1876. He began the practice of medicine in Webster, W. Va., and then located at Grafton, where he remained until his death. He was a member of the West Virginia Legislature of 1887, and again in 1889. In 1901 he was president of the West Virginia State Medical Society, and in 1903 took a special course in the New York Post-Graduate School and Hospital. Dr. Thayer was an Episcopalian, and was for years senior warden of St. Mathias Protestant Episcopal Church at Grafton. He was a member of the Sons of the Revolution, American Medical Association, the Military Order of the Loyal Legion, Grand Army of the Republic, Royal Arch Masons and National Association of Railway Surgeons.

He married November 26, 1868, Miss Virginia Love of Grafton, who died in 1885, leaving two children—Arthur L. and Howard B. Thayer. Dr. Thayer married again October 30, 1890, Miss Kate Virginia Samsell of Grafton, by whom he had six children—Dorothy, Katherine, Marguerite, Helen, Richard S. and Abel H. He is survived by his widow and four children of the second marriage and the two of the first.

Dr. William Kirkwood Robinson, class of 1893, died at his home, 306 Kingsley Drive, Los Angeles, Cal., August 24, 1912, after an illness of several months. He had been living in the West for some years, and specialized in ear, nose and throat work. His remains were cremated in Los Angeles, in accordance with his request. He is survived by his widow, who was a Miss Vickers, of Chestertown, Md., daughter of the late Harrison W. Vickers, and his father, Dr. R. K. Robinson, Sharon, Md.; one brother, John A. Robinson, Belair, Md., and three sisters, Mrs. John W. Staton, Snow Hill, Md.; Mrs. McAllister, Baltimore, Md., and Mrs. Ziegler, Chambersburg, Pa. Dr. Robinson was 43 years of age.

## BOOK REVIEWS

PRACTICAL ANATOMY. An Exposition of the Facts of Gross Anatomy from the Topographical Standpoint and a Guide to the Dissection of the Human Body. By John C. Heisler, M.D., Professor of Anatomy in the Medico-Chirurgical College of Philadelphia. With 366 illustrations, of which 225 are in

color, by E. F. Faber. Philadelphia and London: J. B. Lippincott Company. 1912. Leather; \$4.50 net.

From an experience of many years in the dissecting-room the reviewer can certify to the wisdom of Heisler's arrangement of his material in his book on "Practical Anatomy." Undoubtedly the best way to study anatomy in a systematic manner in the abstract is to take up the several systems independently of each other. In this way the student gets a broad grasp of the subject, but when it comes to the dissecting-room the student is confronted with another problem. Here he finds the organs and structures in relationship with each other—the body in an orderly whole, and not dissociated as in textbooks. Therefore, if a general textbook be employed, the average student finds himself at sea in approaching the subject. Some few students we are aware, after bitter experience, learn to correlate the dissection by skipping about in the book before them and finding out what structures are to be found in the region under study. Heisler's idea of describing the structures as the student reaches them, in our judgment, is ideal if used in conjunction with a standard textbook, and should enable the dissector to save time and gain a more intelligent grasp of human anatomy as it actually presents itself. The division of the contents into sections on the upper limb, the lower limb, the head and neck and the thorax and abdomen cannot, from a practical view, be improved upon. The reviewer has long since learned that medical students' interest in any subject is proportionate as they can see the practical utility resulting therefrom. Heisler has attempted to supply this incentive by including in smaller type such information, either medical or surgical, as has a practical bearing on the part under discussion. In order to familiarize the users with the desirability of simplicity and uniformity in anatomical nomenclature the Basle Anatomical Nomenclature is used wherever feasible, and where not employed is included between parenthesis. Explicit directions are everywhere to be found as to the best and simplest method of making the dissection. The illustrations, many of which are colored, are excellently executed, true to nature and made from original dissections by the author. It supplies a long-felt need in the dissecting-room, is practical, accurate, sufficiently full for its purposes and dependable.



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No. 8

## A SUMMER CRUISE ON THE SPANISH MAIN.

By RANDOLPH WINSLOW, M.D.

### 2. *Colon, Panama and the Canal Zone.*

Colon is situated on an indentation of the coast of the Isthmus of Panama, called Limon Bay. This bay, though on the Atlantic side, looks towards the north, and at certain seasons of the year is an unsafe harbor. In order to obviate this serious disadvantage and to protect the entrance to the Canal, the United States has built a breakwater about two miles in length, which to a very large extent converts this open roadstead into a land-locked harbor. If this is not sufficient to accomplish the purpose, another breakwater upon the opposite side will also be built, leaving only a narrow entrance through which ships will pass. Strong fortifications are also being constructed to defend the canal from attack from the sea. Colon was formerly called Aspinwall, and was built upon a marshy island, scarcely above sea level. Like most Spanish-American towns, its streets were unpaved, and were the depositories of all kinds of filth. The first effort of the United States after securing control of the Canal Zone was to clean up these pestilential cities and towns, and to render them safe from yellow fever, malaria and other zymotic diseases. The streets of Colon and Panama have therefore been raised, curbed and macadamized or paved, and will compare favorably with cities of similar size in our own country. Water-works have been established and an abundant supply of pure water furnished for both drinking and bathing, while previously the drinking water was obtained by catching rain water in cisterns, which were also the breeding places of mosquitoes. Colon has about 17,000 inhabitants, of a very mixed character, whites of varying shades, negroes, Chinese, Hindoos, and people of almost every race and color. The houses are

mostly wooden and are ramshackly in appearance, though there are a few good stone buildings. The town derived its importance from being the starting point of the Panama Railroad, and will certainly continue to increase in population and prosperity from its location at the entrance of the Panama Canal. Although Colon and Panama are within the Canal Zone, they are exempted from the control of the United States except in the matter of sanitation and of preserving order. The railroad tracks separate Colon from Cristobal, which is the American settlement and is entirely within the jurisdiction of the United States. Here the Canal Commission has its great commissary establishment, laundry and many other offices. The Colon Hospital was built by the French and came under the control of the Americans in 1904. It consists of many detached buildings situated on the waterfront, and some of them actually erected on piles in the bay. It is said to have accommodations for 500 patients. There are several long wharfs at Colon and Cristobal at which large ships can dock, and there are usually six or more steamers taking on or discharging cargoes all the time. The Panama Railroad was opened in 1855 and extends 47 miles from Colon to Panama. As first constructed, it was a narrow-gauge road running over swampy ground to the hills, but it has now been relocated upon a higher level, and is a broad-gauge, double-tracked, well-ballasted road. It runs nearly parallel with the canal, but at only a few points is the canal actually visible from the train. All along the line of the railroad one sees the towns in which the employes of the Canal Commission dwell, the houses being raised from the ground in order to permit a free circulation of air under as well as through them. They are usually two stories in height, surrounded by porticoes well screened, and situated on an eminence; and every effort is made to make the life of the employes comfortable and happy. The heavy work is mostly done by West Indian negroes, but the overseers and bosses are white Americans.

As has been stated, the county is flat, marshy and covered with jungle for 25 miles, when it becomes hilly. These hills are the continuation of the Andes mountains, but do not attain any great altitude, Gold Hill being the highest point through which the canal is cut, somewhat more than 500 feet in elevation. One of the detached, more or less conical, hills is called Balboa hill, as it is supposed that Balboa first saw the Pacific Ocean from its summit in 1513. At Las Cascadas a battalion of marines is stationed, and at Empire the 10th infantry has its post. These are elevated, healthy locations, and the camps are kept in beautiful condition. The Canal Zone is policed by fine-looking mounted officers, who go about their

though a line is now being built. There are no detached residences in Panama as far as I could see, but the people live over stores or other utilitarian buildings. Earthquakes do not occur on the Isthmus, hence the houses are several stories in height. As has been said, the streets are now well paved and are kept scrupulously clean, but formerly they were filthy and ill-kept. The population is very mixed, mostly not white, and with a deepseated dislike of the American gringo. As an illustration of this, on the 4th of last July there were athletic sports held in the city, at which American soldiers, unarmed, were present. Two soldiers having a personal quarrel, and probably under liquor, went upon a vacant lot to settle



FRONT STREET, COLON.

duties in a very businesslike manner. Descending on the Pacific side we reach Panama in  $2\frac{1}{2}$  hours from the time of leaving Colon. The conductors and engineers of the trains are Americans, and the nasal twang of the Yankee is very much in evidence. Panama city is situated on a bay of the same name and has a population of between 30,000 and 40,000. It is quite a bustling town, with many stores, narrow streets and scrawny horses attached to dilapidated carriages. A ride within the city costs 10 cents a passenger, but that means in American coin. I paid a driver the amount he asked and supposed I had given him the correct fare, but I had paid in Panamanian money, which is one-half the value of our currency, and he was mad all through about it. There are no street cars at present in Panama,

their dispute in the usual manner, when they were fired on by the native police. Of course, their comrades came to their aid and a melée ensued, in which two Americans were killed and several wounded. It is thought that this was a political act to force American intervention in order to prevent the election of the popular candidate for the presidency. It was with great difficulty that the American troops were kept from entering the town and killing the police. For the size of the city the police force is very large, though the individual members of it are very small. The Americans with no arms, except bayonets, were anxious to attack the whole Panamanian police force, armed with modern rifles. Our Government has demanded satisfaction for the attack on its citizens and the punishment of those who were the

ringleaders in the outrage. The native women wear their hair down their backs and a silk shawl around their shoulders in the Spanish fashion; while children are frequently seen clad only in the garb of nature. Some of the churches and the cathedral are of interest, as well as of antiquity. There are ancient and useless fortifications overlooking the sea, dating from the early days of the city. The present city, however, is not the first one of the same name, but is located about five miles from old Panama, which was sacked and destroyed by the English freebooter, Sir Henry Morgan, in 1670. The original city of Panama was founded in 1519, and after its destruction by

Pacific entrance of the canal. Here one finds steamship lines to Peru, Chile and the other countries on the western coast of South America, as well as the Pacific Mail steamships plying between Panama, Central America, Mexico and San Francisco.

The name Balboa is very prominent on the Isthmus: I have already mentioned Balboa hill and Balboa port, and one is constantly reminded of the historic personage who first gave the Pacific Ocean its name, as the standard coin is the balboa, equal to 50 cents in our money. Immediately contiguous to Panama is the American settlement of Ancon, where the administration headquarters are



CENTRAL AVENUE, PANAMA, AND NATIONAL BAND.

Morgan was rebuilt on its present location; it is, therefore, the oldest city of continental America. At one time it was the port through which the Spanish treasure came from Peru and the western coast; subsequently it lost much of its importance, which was in a measure regained on the opening of the railroad in 1855.

With the completion of the interoceanic canal in the near future, it is bound to become one of the important ports of the world. Panama Bay is shallow and there is a daily variation of 21 feet in the tide, so that the water comes against the sea wall of the city at full tide, and recedes a long distance at the ebb. Ships, therefore, cannot approach the city, but land at Balboa, which is the

located. Here also is the large and comfortable Hotel Tivoli, built by and under the control of the Canal Commission. The fare is \$5 per diem; but one gets a good airy room, clean sheets and bed linen, and beds that are not overtenanted, as well as good meals. It is said that these essential requisites cannot be obtained in the hotels in the native town. The view from the hotel porch is beautiful, as the blue waters of the bay are spread out before us, dotted with islands of emerald green and animated with sail and steam boats of various kinds. Still higher on the hill back of the hotel is the great Ancon Hospital, erected by the French and taken over by the Americans in 1904. This hospital consists of many detached buildings,

usually of one story, but some are two stories in height, severely plain in construction, with screened windows and doors through which an abundant flow of air is permitted. The Americans have erected but few additional buildings, and the institution is a monument to the excellence of the French physicians and builders. Its original cost was several million dollars. The capacity of this hospital is about 1500 beds, 400 of which are for surgical cases. The Americans took charge about June, 1904, and up to the time of my visit on August 23, 1912, a little more than eight years, 123,000 patients have been admitted. Dr. Her- rick, the chief surgeon, very courteously took Dr.

physicians or to the hospital, but are turned over to the Canal Commission. The staff are treated very well, however, as the chief physicians receive \$6000 a year, besides comfortable houses and equipages, and the junior officers are also well paid. It was a great pleasure to me to find Dr. Howard V. Dutrow, class of 1904, at work at the hospital, and I am indebted to him for many courtesies. Dr. James C. Perry, class of 1885, is chief quarantine officer of the Isthmus, and is an important factor in preventing the introduction and spread of infectious diseases.

The Canal Zone extends five miles on each side of the canal and is under the exclusive control of



PALM AVENUE. CRISTOBAL, CANAL ZONE.

Felty of Hartford, Conn., and myself through the surgical wards and showed us some very interesting cases, especially of fractures treated with intramedullary splints. Not only, however, are medical and surgical patients treated, but the various specialties—eye, ear, throat and nose, gynecology, and even obstetrics—are under the care of skilled attendants. The reputation of the hospital has become so extended that pay patients from the surrounding countries as well as from Panama seek the skill of the physicians and surgeons attached to the hospital.

While I was there the wife of the present President of Panama was a patient in the pay pavilion. The fees for the private patients do not go to the

the United States. There were and are native villages within this strip, but many of them will be covered with water when Gatun Lake is filled, and they have already been removed to higher land. Most of the American settlements will also be abandoned, and the Zone will be to a large extent depopulated, only leaving a sufficient force of employes to care for the canal. I did not have time and opportunity to get a good idea of the country or to estimate its advantages as a place of residence or business. There did not seem to be much arable land in the portion through which I traveled, nor did I see anything under cultivation except bananas. The canal employes receive their food supplies entirely through the cold-

storage plant at Colon, which must be replenished every two weeks. The foliage, while abundant, was not especially pretty, nor were the flowers of the same delicacy and beauty as in more temperate climes. There were, however, some curious and attractive flowering plants. I presume there must be an abundant bird and animal life in the less frequented regions, but they were not in evidence in the parts I visited. As to the climate, it is hot, but not more so than that of Baltimore in mid-summer, and there is usually a good breeze, but the great humidity is very unpleasant and depressing to those who are not acclimated. Some of our officials have now lived there ten or more years, and not only appear to live comfortably, but to enjoy life.

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### INITIAL ADDRESS TO THE JUNIORS AND SENIORS.

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Delivered by ERNEST ZUEBLIN, M.D.

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"Not enjoyment and not sorrow  
Is our destined end or way;  
But to act, that each tomorrow  
Finds us farther than today."

The pleasures of the seaside, or of the cool mountains, or the recreation at your homes, perhaps, has come to a close. The possibility of alleviating the sorrows of suffering mankind will compensate you, I hope, for the regret you feel in leaving so many pleasant scenes behind. You have answered the call of your Alma Mater in assembling again in her halls. I wish to extend a cordial welcome to all my pupils. After the idleness of the vacation you feel the necessity of resuming your studies. You know that much work has to be done before you reach the rank of an accomplished physician. For some of you it means the entry into a new field of activity, and I venture during the sometimes tedious preparatory studies of former years you longed for the moment to get into closer contact with the professional duties, the application of your knowledge to the relief of suffering patients. For some of you this year means the completion of your studies, after the careful instruction you owe to the knowledge, experience and personality of your previous teachers, among whom stands prominently Prof. C. W. Mitchell. It is with regret that you have heard that the accumulation of work in the inter-

est of the University induced your former teacher to restrict his teaching in medicine for the benefit of the juniors only. As you may be accustomed to the methods of my distinguished predecessor, you may regret this change. But every teacher's aim is the same; it is to see you advancing on the way to become a distinguished physician, gifted with knowledge, experience and untiring energy in the fight against human disease, and provided with all the necessary qualities that will assure you a prominent standing among the members of the medical profession, as well as a numbering among the benefactors of humanity. So, in the acceptance of the honor conferred upon me by the decision of the Board of Regents and by the members of the Faculty of Physic of our famous Alma Mater, let me hope that our work, based on mutual understanding, will be successful for all of us.

Medical science has a peculiar attraction for her disciples; like a mountain we see it rise from the plain, and we wish to reach the top in order to obtain from there a more distinct view of the world. On the way to this elevated position we have to overcome many difficulties, and on the stony path there are moments when our strength seems to fail, and where a word of encouragement, of good cheer from our guide sets free new resources of unknown energy. In the course of your studies you learn how your knowledge is built up from little facts, which by themselves seem unimportant, but which are quite significant in the final outcome from cause and effect. Medical education is a process of evolution—the continuous development of the student into the practitioner. The final result depends greatly on the personal contact of the teacher with his pupil. It is greatly influenced by the interest and enthusiasm of the teacher in his work and the industry displayed by the student. A certain affinity between teacher and pupil has to be created; mutual understanding in the ways and aims of education has to be cultivated in order to accomplish a good result. The teacher has to reply on a certain collaboration on the part of his students. Thoroughness, perseverance and love for the work has to be fostered in the student. Considered from this point of view, medical teaching comprises an eminent task, which becomes still more difficult in the hands of an outsider. Just as medical science has become a benefit to the whole of humanity, so the methods

of its teaching, not restricted to one particular seat of learning, find their way everywhere. What seems good for one place may be helpful to another if the proper conditions prevail. So, my friends, in beginning our work I hope that my experience with eminent clinical teachers of your own and of the old country will turn out to the benefit of our Alma Mater and of her students. Knowing that our work is based on the accomplishments of our ancestors and predecessors, we try to continue only with the aim to adapt it to the present and future requirements. So this does not mean that I discredit the work already accomplished; only it means that in the course of time I wish to develop your clinical knowledge on the basis you owe to your previous teachers.

The medical profession can be viewed under very different angles. To some men it means a successful way for making money; for the acquisition of all the means that contribute to the happiness of life. It is justified that every work receives its true reward, be it good or bad. If you analyze the lives of medical men who, owing to their work and to their personal qualities, have reached eminence, you will find the medical profession meant more to them than a safe, successful, prominent position in life. Physical as well as spiritual life is a process of evolution, and a process greatly influenced by education, surroundings and ethical training. I assume that all of you, brought up and strengthened in the principles of religion, remember that one of the principal manifestations of spiritual life and one of the most important commandments is that of charity. To my mind, there is hardly any other profession where charity and science amalgamated can do more for humanity. Science taken for itself may be compared to a limelight penetrating into the darkness of ignorance, but leaving the heart cold. In the contact with human suffering we often feel depressed and discouraged, and our wish to abolish all evil is felt intensely. But sentiments alone avail nothing; scientific help and sentiments combined can relieve human sufferings. Charity blended with medical science and experience is the source from which we can draw new energies, destined to adorn the existence of mankind. Daily experience shows us the truth that a good man alone can become a good physician, a man with a firm character, gifted with that idealism that holds out against all difficulties of life. A physician

remaining all the time on the ground of thorough science may inspire his circle of students and patients with admiration, and his knowledge may be a great blessing for his patient. Yet he is apt to consider suffering human beings as mere material for observation and experimentation, and he may even try in his cases remedies which will not stand the test of ethical judgment. His presence sends forth a cold, bright light; it will not warm the heart of his human patient, who is in need of sympathy and kindness as well as of medical treatment, if no word of sympathy or kindness for the patient accompany his actions. How different the atmosphere that emanates from the physician who brings to the bedside knowledge and psychological understanding of the suffering! Without many words the understanding between patient and physician is established. In the former the comforting feeling is aroused that he can trust his doctor in everything. And even if our efforts to save a human life are of little success, the refined physician can render great services in alleviating the patient's physical and mental sufferings when he is about to depart from this life. If we consider the rôle of the family physician to whose faithful services whole families are indebted for his devotion and skill where he is not only consulted in medical questions alone, but where his advice is highly accredited, can money be the just compensation for such help? The financial equation remains often below the standard, but even then it does not equal the satisfaction experienced in the physician's soul, knowing that he has done his best for his cases. "Noblesse obligé," if not immediately, it will later on. If we investigate into the motifs of generous donators, we may not unfrequently find that the example of an unselfish, persevering physician created in the mind of the donor the desire for such noble actions. So it will also be your task by your work, by your learning and your professional services to impress on your patients the commandment of charity, and in doing so you may be of great help in the progress of science also.

Science gradually directs us to a higher standpoint for observation of mankind. Just as daily experience shows the truth of the old maxim "*mens sana in corpore sano*," we observe how a diseased body transforms the mentality of chronic suffering patients. We feel compassion for them, and all our efforts are tended to alleviate their

physical and psychical condition. The high education given to the physician has rendered him as solid, as resistant as a rock, against which the waves of ignorance, of superstition, of selfishness and ingratitude of the public are of no avail. During the years of studies you have reared and elevated among your fellow-students the sentiments of friendship, of collegiality, which does not admit thoughts of animosity or jealousy. When you have entered a practical life, you will never foresake these noble convictions which adorn your professional life. No doubt science has an elevating influence on yourself, and if the progress of medical science represents a glorious history, written with the blood of its promoters, you certainly acknowledge these results of untiring work of past generations. Science does not only include the obligation of recognition; it kindles our energy to contribute to the best of our ability to its further progress. Among the alumni of our University you certainly remember the name of Dr. James Carroll, who offered his life as a martyr for the progress of medical science. His assertion, "Truth will prevail," should also enter into our convictions, and we should be able to accomplish for humanity as much as he did. My friends, if ethical training and medical science corroborate each other, let me hope that you will show the world what a mind enriched with acquisitions of medical science, strengthened by exercise and led and inspired by an ardent and sensitive heart can accomplish for humanity.

With such a view into your future let us, my friends, begin the work. Which are the necessary requirements I have to expect from you? Thoroughness, perseverance and love for your work have already been briefly mentioned. In a task in which your future happiness, your professional success is at stake, I have to insist on the necessity of pursuing your medical studies in this clinic also thoroughly. I cannot lay enough stress on this quality, as it seems to me the "one" essential for the medical man—one factor upon which your future depends. You may analyze the factors which contributed to the fame of clinical teachers, and you will always find that they were thorough in the least details of their work. Hardly any fact, even seemingly unimportant to the patient, escaped their attention in taking the history. Thoroughness characterizes their examination of the whole body, where all

organs may suffer. After the exhaustion of the means of clinical physical examination, they try to unite all findings, all knowledge, every experience, and a kind of medical instinct allows them to separate primary cause from secondary consequences as much as possible. Their diagnosis dives to the bottom of the cause of disease, and after a careful consideration of prognosis the treatment is before all causal, if necessarily symptomatic and prophylactic. In a process where analysis is followed by synthesis, where clinical findings and didactic knowledge or the symptomatology, of pathology complete each other, where the body of the patient does no longer mean an organ in which darkness prevails and wherefrom only little information is transmitted to its outer surface. As long as our physical means are not yet able to transilluminate completely the human organism, we are still obliged to train our senses, our mind, so as to penetrate the secrets of the body by mental analysis. The future will show that the patients will learn to distinguish very well the thorough physician from his colleague, who does not think it worth while to concentrate his interest on his patient's disease, and who, without a careful examination, resorts to symptomatic, in many instances to unsuccessful, treatment. I know that untrained human beings are naturally inclined to avoid difficulties. In education it is one of the most important tasks to create in the pupil that sentiment of responsibility in the work to be accomplished, to develop in the pupil the courage to tackle difficulties directly and with enthusiasm (*nec aspera terrent*). It means, no doubt, a hard task not to follow the tendency toward lesser resistancy, not to take it easy. History and daily observation demonstrate that the world belongs to the conqueror. Also, with reference to the success of the medical student in doing thorough work, he will not only merit the recognition of the patients, the encouragement of his teachers, but most valuable of all will be the personal satisfaction experienced by the success in treatment of disease. It may appear easier in the beginning not to care much about the quality and quantity of the work accomplished, but later on the results and consequences of the work done are quite different. Once started into medical practice, no more within reach and control of the medical teacher, the practitioner will learn his mistakes at the risk of his patient's welfare. Thoroughness



means an important habit to adopt during your studies, but which will become second nature and then pay itself manyfold by the success it warrants. If the fatal results in surgery are often caused by very little errors and small neglects, so in medicine carelessness may cause almost similar consequences. So, my friends, I shall judge your fitness for a good final grading by the evidences you give of your thoroughness in your studies and in the examination of the cases.

Before we begin our work let us consider a certain outline of our clinical studies, first for the junior men, then that of the seniors. After the completion of your previous studies it is most important to master the principles of physical diagnosis, and to make extensive use of your experience, first in normal cases among yourselves, and later, when you have become familiar with the physical signs of normal conditions, you will train your senses on your patients. Then, notwithstanding the excellent preparatory instruction given to the student as soon as he enters the practical clinical studies, it seems, that he has first to be taught to use his senses. His power for close observation of the patient has to be developed, as the outward observation of the patient already in many instances can furnish important information of the case. The ear requires the subtle training of the musician to differentiate the quality, the tonality of the sounds transmitted to the surface of the body. The delicate touch of the fingers has to be trained to differentiate the outlines, the resistancy, the qualities of vibration of the underlying organs. The acuity of smell has to be educated in order that pathological changes imparted to the air, may not be overlooked. All these requirements, in addition to your practical training in the manipulation of instruments and apparatus, in the chemical and microscopical clinic, diagnostic methods, etc., are important factors in medical diagnosis, and they are obtained only by an assiduous, thorough training in the methods of physical diagnosis. Hand in hand with this instruction in following the medical clinic you will reach the understanding of the cases, of the methods of examination, of differential diagnosis and the principles of treatment. Frequent study of your textbooks on internal medicine will complete your knowledge of the clinical features of the presented cases. So, with your collaboration, I hope that our work

will be so successful that whenever questions are addressed to you they will be answered readily, so showing the senior men that your knowledge increases every day, and that you are keen to enter into friendly competition. The necessity of practical and theoretical understanding in clinical medicine is obvious. In lectures on didactic medicine you will gradually get acquainted with the terminology, symptomatology, pathological anatomy, diagnosis, prognosis and treatment of human internal disease. If we briefly outline the task of this year for you, the senior men, your instruction is partly didactic, mostly practical. Certain chapters of internal medicine require a more detailed discussion. In the previous year, I assume, you have had clinical cases demonstrated by my predecessor, Professor Mitchell. Now, each one of you will in turn be assigned one clinical case, which you will thoroughly examine and then submit your clinical findings to me for control, for discussion of the differential diagnosis, prognosis and your plan of treatment. This will be done here in public, in presence of the junior students. From time to time you will report on the course of treatment of your cases; also on the changes of its clinical features. Gradually seeing that you have mastered the general routine examination, it will be the aim of our conferences to enter more in detail of the clinical aspect of cases, comparing them with the material you have already seen and with pathological specimens, so that at the end of your term you will have gained a thorough knowledge of the different internal diseases, didactically as well as practically. With your clinical instruction at this place and the clinical material from the polyclinic, a great field of work is opened to you, and in appreciating your zeal, your understanding and your earnest work, I wish to help you all to become thorough, well-experienced practitioners in internal medicine. So, gentlemen, the plan I have briefly outlined means a great task, but I count on your earnest perseverance in your work, and gradually I expect to watch your further progress, so let me hope that, following the device of our Alma Mater, *Omnia probate quod bonum est tenete*, we will accomplish our duties.

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Dr. Russell Hardy Dean, class of 1912, of Jacksonville, Fla., has been forced, because of ill-health, to go to the mountains of North Carolina for relief.



## REASONABLE AND PLEASURABLE.

By NATHAN WINSLOW, M.D.

Travel has been made so safe, reasonable and comfortable these days that everybody should, if possible, become acquainted with his own country. Instead of hibernating at a summer or mountain resort, sitting around and gossiping, better use can be made of the time at your disposal by visiting new scenes and getting new ideas. With this object in view, accompanied by Mrs. Winslow, I sailed September 11, 1912, from Baltimore on the Merchants & Miners' steamship Suwannee for Savannah and Jacksonville. This vessel is one of the best appointed coastwise steamers that sails out of any Atlantic port, being fully equipped with every convenience necessary to the comfort of its passengers and providing a substantial and excellent cuisine.

The trip down the bay was made at night, and the next morning by 8 found us passing between the capes into the ocean. Thursday was spent on the ocean, as well as a part of Friday, the Savannah River being entered about 9 P. M. on the latter day and the boat docked by 11, where it remained until 7 P. M. Saturday, sailing thence to Jacksonville, which was reached 10 A. M. Sunday morning.

Savannah is situated on the south bank of the river of the same name, 18 miles from the sea, on a level plateau about 50 feet above sea level. It is a very attractive city, with numerous parks and some very pretentious buildings. Everywhere you turn you run into a small square or park, not, as in Baltimore, posted with signs of "Keep Off the Grass," but given over to children as play and airing grounds. The streets are well paved, mostly with vitrified bricks, and well-made roads lead into the surrounding country, thus offering opportunity for enjoyable auto and buggy drives.

The show place of Savannah is the Bonaventure Cemetery, with its magnificent live oaks, from which hang in festoons streams of Spanish moss. While in this city we called upon Miss Raines, a graduate of the University Hospital Training School for Nurses, now superintendent of Oglethorpe Sanitarium, and were shown through the hospital, which accommodates about 35 patients. It is a very attractive and well equipped building. While there I met Dr. Ray-

mond V. Harris, class of 1907, who took us around the city in his motor car. We traversed miles of well-paved streets and well-made country roads, passing through substantial developments, dotted with attractive, modern homes. The courthouse, city hall, custom-house and postoffice are all modern and architecturally pleasing. Savannah leaves the impression of a conservative, but substantial town, not going ahead too rapidly, but steadily and naturally. This impression was afterwards verified when I learned that in point of export trade Savannah ranks seventh, being next in importance to Baltimore.

The River Queen has made the Savannah River famous. This lady, who, together with her brother, keeps a river lighthouse, never fails, night or day, to salute a passing vessel—at night by waving a lantern, by day a handkerchief. By some a romance is supposed to be attached to the action, and the common story is that the woman became demented by the loss of her lover at sea, and since then has saluted each vessel, hoping that he may yet pass by and recognize her. The story as related is very pretty and has a natural ring, but is a myth, the woman being entirely rational and never having had a lover—at any rate, one who was lost at sea.

Jacksonville is a 12-hour sail from Savannah. It is situated on the west bank of the beautiful St. Johns River, 25 miles from the ocean. It is very progressive, and jumping by leaps and bounds both in population and commercial importance. Everything going into or coming out of lower Florida must pass through its walls, thus making of it a commercial mart of great importance. It is a large lumber, citrus, turpentine and produce shipping center. The streets, though narrow, are well paved, mostly with vitrified brick. In the business section are to be seen a number of modern office, banking and trust buildings. Here are also to be found numerous parks, full of bright-colored flowers, live oaks, sycamores, chinatree, magnolia and palm trees. The banana tree grows in this latitude, but only exceptionally bears fruit. The residential districts are attractive and contain quite a number of imposing houses.

While here I called up Dr. Norman M. Heggie, class of 1902, who is a leading eye, ear, nose and throat specialist. He has built up a large practice, and we are glad to announce is held in the greatest respect by his associates and clientele. He took

us in his automobile around the city and a long ride to Pablo Beach, 18 miles from Jacksonville, on the Atlantic Ocean. On this ride we passed through miles of pine forest, from the trees of which turpentine was being extracted. At Jacksonville there is a large ostrich and alligator farm. It was indeed a rare sight to see over 700 alligators, of all ages and sizes, in one enclosure.

While I was in Jacksonville I had the pleasure of seeing, besides Dr. Heggie, Dr. Russell Dean, class of 1912; Dr. James D. Love, class of 1897; Dr. Charles Leitner Jennings, class of 1906, and caught a glimpse of Dr. George Walter, class of 1910, as he flew past in his auto. Dr. Robert H. McGinnins, class of 1897, and Dr. James B. Parramore, class of 1909, were out of the city. I called up Drs. Charles Edward Terry, class of 1903; Fred J. Waas, class of 1905, and Dr. Louis Stinson, class of 1911, by phone, but could get no answer, so was compelled to forego the pleasure of seeing them.

With Miss Nettie Flammigan, class of 1901, of the University Hospital Training School for Nurses, who is superintendent of the De Soto Sanitarium, we spent a very pleasant afternoon automobiling around the surrounding country.

A day was also spent in St. Augustine, the oldest city in the United States. It is 40 miles distant from Jacksonville, located on the Matanzas River, and is a place of great historic interest. Here is to be seen the Old Spanish Mission Building, without doubt the oldest building in America, the records of which are preserved in the archives of the Church of Rome. The Ponce de Leon and Alcazar hotels are magnificent samples of old Spanish architecture, and the "Fountain of Youth," discovered by Ponce de Leon on Easter Sunday of 1513, a quaff of whose waters was supposed to restore youth, never fails to interest. It possesses, however, one peculiarity—the water rises and falls without any apparent reason or cause. Old Fort Marion, the only example of medieval fortification in existence on this continent, was built in 1565 by Menendez, and named San Juan de Pinos. It was rebuilt as Fort Marion during the seventeenth century. The City Gates, like those of Panama, remain to tell of the Old World civilization that once dwelt within the city walls; the slave market, which was never so used save in rare instances; the narrowest street in the United States, but seven feet wide at its east end; the Cathedral of St. Augustine, built in 1797; the

old Franciscan Monastery, now the arsenal of the Florida National Guard, and the houses of coquina, a shell formation—one after the other present a panorama of never-ending interest and entertainment.

The return voyage was over the same route. Outward bound Dr. Adam Clark Walkup, class of 1909, of McIntosh, Fla., was among the ship's company. He had been spending a few weeks' vacation in New York, and was on his way home. Dr. Walkup was looking in the best of health, and told me he had been very successful and was building up a good practice.

Although the trip was replete with many new and novel sights, and was thoroughly enjoyable from beginning to end, my greatest pleasure and satisfaction was in the evident prosperity and happiness of our alumni now located in those cities.

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Prof. Randolph Winslow is in receipt of the following letter from Dr. Edward L. Meierhof, class of 1881:

"My Dear Dr. Winslow:

"Enclosed please find my promised instalment as a contribution to the P. E. F. I have just returned from abroad, where I had attended the clinics at Jena, Vienna and Berlin. The old town of Jena I found very interesting. It is the home of the great Zeiss Optical Works, which cover about three of New York city blocks, or more. Some of the profits of this institution are given to the support of the university and hospitals. It is also the home of Ernst Haeckel, whose popular book, 'The Riddle of the Universe,' has helped to spread his name and fame. Vienna has a new hospital devoted to nose and throat diseases. It is splendidly equipped, especially for teaching. It is part of the Allgemeines Krankenhaus, and is attended by many 'Amerikanische Aertzte.'

"Berlin is a lively and hustling town. There are not as many of our countrymen pursuing the furtherance of clinical knowledge as in Vienna, although I profited very much by my stay in Berlin, as well as in the other places.

"With best regards, from

"Yours sincerely,

"E. L. MEIERHOF."

P. S.—I think you are the youngest man I have had the pleasure of knowing.

## THE USE OF IODINE IN OBSTETRICAL PRACTICE.

(In 264 cases with no infection.)

From the Clinic of Dr. Sprigg and Dr. Kelley,  
Columbia Hospital, Washington, D. C.

By WILLIS LINN, M.D., Resident House  
Surgeon.

Following the marked success of the use of iodine in preparation of surgical cases, it occurred to us, as perhaps it has to others in the same line of work, that its use in obstetrical cases might be of benefit. The objection was raised by some that the use of iodine in the external genitalia would be far too irritating. We have not found that it causes any irritation, the patients complain for a moment directly after it is applied, but aside from this transitory burning the irritation caused is negative. The method pursued is as follows: As soon as the patient is placed on the delivery bed the pubic hairs are clipped with scissors; shaving is unnecessary and causes much more inconvenience after delivery. The parts are then dried of mucus and any amniotic fluid that may be present, if the membranes are ruptured, a 50 per cent. solution of tincture of iodine in alcohol is then applied, commencing at the umbilicus and including the lower portion of the abdomen, the entire genitalia well down on the buttocks and inner side of legs and thighs. A sterile vulval pad is then put in place, and the remainder of the preparation consists in merely placing the patient on a sterile bed pan and placing the sterile covers on. These last are not done, however, until bulging is marked. In using the flat sterile bed pan in delivery cases, the Kelly pad is done away with altogether. Time and expense are thus both saved and the pan is much easier to sterilize than is the pad. The method is quick. The slop and dirt of the old bichloride preparation is done away with, and the inflammation which certainly occurred in some cases when using the bichloride is overcome. We have had no cases of inflammation following the use of iodine. Dr. Charles Duffy of Pittsburgh tells me that he has seen two, but that the use of glyceride of starch applied locally cleared them up in less than 24 hours. In hospital maternity work, where cases are constantly being sent in, which

have been examined by septic fingers before delivery, we separate the labia as far as possible and carry a sponge on a hemostat well up into the vagina, thus applying the iodine to the interior. Of course, in these cases, we are going against the advice of Bovee, who showed the surgical world that iodine acts best on a dry field, but we have gotten results that prove that iodine will and does sterilize the vaginal canal. It is doubtlessly better on a dry field, but in cases that have been previously examined it is well to use it in the interior as well. In that large class of the cities' poor and lower classes, where a physician is often not called until delivery is all but complete, it has proven very satisfactory; and in the private home, where trained assistants are so often wanting and the old method was hard to carry out, it should be most satisfactory.

I see no reason why it could not be intrusted to midwives, and in this way might save not a few lives from that most dire of obstetrical results—puerperal sepsis. The 50 per, as it is now commonly called, does not end its usefulness in obstetrics here, for after the cord has been tied and cut its application to the end of same assures at least a clean field. This will not appeal to men in hospital work where the technique is certain, but in the "private home" and in the hands of the midwife it seems to us that it would not be amiss. We do not claim for the method that it is original with us, but it does surely possess the following advantages:

1. It is quick.
2. It is sure.
3. It shows the exact field of operation which has been sterilized.
4. It can be done without assistance from anyone.
5. Aside from the temporary burning it causes no inconvenience to the patient.
6. It does away with the wet, sloppy "bichloride bath."
7. It brings results.

May 19, 1912.

The engagement is announced of Dr. William Gwynn Queen, class of 1909, of Arlington, Md., to Miss Loretta Wholey, daughter of Mr. and Mrs. William Wholey, of Staunton, Va. The marriage will be performed at St. Francis Catholic Church on Tuesday, October 15, 1912.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, OCTOBER 15, 1912.

## BERI-BERI CLINIC.

Professors Zueblin and Spear will hold in the amphitheater of the University Hospital on Monday, October 21, at 8.30 P. M., a clinic on beri-beri, with exhibition of cases. All those interested in this disease, rare in this section, are cordially invited to be present.

DR. J. HOLMES SMITH, SR.

The editor of THE BULLETIN cannot let pass the retirement of Dr. Smith from active practice in order to devote his entire time to the department of anatomy without recording our sentiments concerning the act. A protocol was issued by the Regents of New York that medical schools to be registered in that State must have at least six full-paid instructors in the laboratory branches. In order to meet this command, Dr. Smith, without a murmur, consented to forego the remuneration of a large and lucrative surgical practice. Such acts of unselfishness marks a man—a patriot not alone to the cause of education, but also to an ideal, a greater University of Maryland. THE BULLETIN appreciates the motive which induced Dr. Smith to devote his attention to pedagogical work, and desires to take this opportunity in wishing him many years of usefulness in his newly-mapped-out career.

## THE OPENING OF THE SESSION 1912-13.

The 106th annual session of the medical department of the University of Maryland began on October 1. At this time it is impossible to state

how many students will be in attendance, as the enrollment is still going on. It is thought, however, that there will be fewer new students than usual, owing to regulations enforced by the New York Board of Education. There have been many applications for advanced standing from students of other colleges, who wished to obtain better clinical facilities than those offered by the institutions in which they had taken their first two years' work, but we were unable to accept them, owing to the New York regulations. These were not conditioned students, but men who had successfully completed their first two years in respectable schools which we have hitherto recognized and which we still believe to be good and honorable schools. We think that the New York ruling in regard to these schools is unduly drastic, but we have obeyed their mandate. We are glad to announce that the State Board of Medical Examiners has taken supervision of the entrance requirements of medical students in this State, and that Professor Otis of the Baltimore Polytechnic Institute has been appointed official examiner of the credentials of prospective medical students. Students are therefore only admitted to the medical colleges when they present certificates from Mr. Otis giving them premission to do so. The admission of students is therefore entirely out of the hands of the deans, which simplifies the situation very much. The uncertainty in regard entrance requirements and the rapid advancement of educational qualifications will undoubtedly deter many from the study of medicine, and the entering classes will probably be smaller than usual this winter.

## IMPROVEMENTS AND CHANGES.

Much has been done since the last session to put the medical school on a better basis. First of all, six full-time salaried instructors have been secured; and a new professor of medicine, who is also a full-time teacher, for this winter at least. The anatomical and chemical theaters have been beautifully renovated, and a fine museum has been established. A balopticon has been purchased and will be set up in the lower hall.

Davidge Hall has not only had a coat of paint, but a steam-heating system has been introduced. New shelving has been put in the library, thereby greatly increasing its capacity. Many new books have been donated and some bought. The main

lobby of the medical school has had a fine terazzo floor laid. Much painting and calcimining has been done in the lecture-rooms and laboratories. A new clinical laboratory has been established at the hospital. The former lying-in hospital has been converted into a polyclinic for general medical and children's diseases. New apparatus has been purchased, and a new spirit of enthusiasm and of optimism prevails.

### THE PATHOLOGICAL FUND.

*Festina lente*, or make haste slowly, is doubtless a safe adage, but it has its disadvantages when applied practically. The above aphorism is forcibly impressed on the mind of the writer by the present state of the endowment fund. It certainly does not make haste in any direction except slowly. The best that can be said of it is that it does progress slowly. Hope deferred maketh the heart sick. Please do not defer your contributions until our heart becomes too sick for recovery. All of which means: Please help us out.

#### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	81 84
1873.....	441 83
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	105 00
1899.....	50 00

1900.....	215 00
1901.....	260 00
1902.....	330 00
1903.....	315 00
1904.....	135 00
1905.....	220 00
1906.....	165 00
1907.....	110 00
1908.....	20 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to Oct. 1, 1912..\$10,250 17

#### NEW SUBSCRIPTIONS IN SEPTEMBER.

Dr. Wm. K. White, 1902.....	\$25 00
Dr. Watson S. Rankin, 1901.....	20 00
Class of 1872.....	11 84
Class of 1873.....	11 83

Total ..... \$68 67

### DR. ERNEST ZUEBLIN.

Some time back THE BULLETIN notified its readers that Dr. Charles W. Mitchell was com-



DR. ERNEST ZUEBLIN.

pelled, owing to press of other duties, to give up the chair of Practice of Medicine and limit his efforts in medical teaching entirely to his first love, the children's department. Coincidentally with this announcement there appeared the call to the vacancy and its acceptance by Dr. Ernest Zueblin, together with a short sketch of the appointee's life and qualifications, and the prognostication that he was the right man for the place. A closer acquaintance with our new professor has strengthened us in our previous opinion of him. We are particularly impressed with the method he has employed in organizing his department. The slightest detail does not seem too small to merit attention. He is, according to a slang expression, "on the job," and if his enthusiasm and earnestness are criteria, we bespeak for the medical department of the University of Maryland a prestige second to none in the country.

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### ITEMS

The most recent work published by a member of the faculty of medicine is a Manual of Practical Physiology, by Prof. John C. Hemmeter, LL.D., Ph.D.

A number of highly interesting and valuable reviews and comments upon Professor Hemmeter's Manual of Practical Physiology have been received. These are by authorities so eminent and who give their opinion so rarely that the editor believes they should be brought to the notice of the readers of the HOSPITAL BULLETIN.

One is by Prof. H. J. Hamburger, the professor of physiology at the Royal University of Groningen, who writes:

"May I heartily congratulate you on the completion of this excellent work? It will be a splendid adviser to me and I shall not fail to recommend it to my students immediately at the beginning of the next course in the warmest manner."

Dr. E. Laqueur has published a review of it in the *Biochemisches Centralblatt*. He begins in the following manner:

"This Manual of Physiology deserves to attract the attention also of German students and readers;" and after reviewing the various chapters in some detail he continues:

"An extensive series of vivisection operations, though clearly and concisely given, will hardly be capable of execution by German students, in the

time at their disposal, but their concise yet comprehensive presentation is well suited to give the student a picture of the physiological operations which are so important for our modern concepts.

"The illustrations are highly instructive, those from the Woods Hole Laboratory of the United States Bureau of Fisheries being so simple, yet clear, that one cannot fail to detect the experienced work of Professor Hemmeter."

Professor Brubacker of Jefferson Medical College:

"In the first place, let me congratulate you on the successful manner in which you have accomplished your object. In the part of the book relating to muscle and nerve, and to physiology of the heart, the experiments are well selected, the methods of performing them carefully indicated, and therefore the student himself should have no difficulty repeating them. In the latter half of the book the experiments seem rather difficult to carry out by students in classes, owing to the apparatus required and the inherent difficulty of some of the problems. With small groups and an efficient demonstrator, they will prove most instructive. I hope the book will have a large sale, and thus contribute to the development of physiological science along practical lines."

Prof. William T. Councilman, Harvard University:

"I have received and gone over your Manual of Physiology, which I think is extremely good."

Prof. J. B. Pawlow, director of the Imperial Russian Institute for Military Medicine, St. Petersburg:

"*Highly Honored Colleague*—I bring my best thanks for the kind presentation of your book, Manual of Physiology, which I have read with great interest. The working out of a normal plan for practical demonstration and study of physiology is the most important object of the present time, and in which you have succeeded."

Professor Pawlow is universally acknowledged to be the foremost physiologist of the day.

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Dr. William Wilhelm Craven, class of 1903, of Huntersville, N. C., was appointed resident physician in the McKeesport (Pa.) Hospital shortly after graduation, and served there a year, then went to North Carolina, where he opened an office in Huntersville. Dr. Craven remained in Huntersville a little more than a year, and had a most excellent practice, but decided to give it up to

accept a position as physician for the Carolina, Clinchfield & Ohio Railway Co., which at that time was extending its lines through the mountains of Western North Carolina. He served with them two years, then returned to his former location in Huntersville and again took up his practice there. Dr. W. S. Davidson, class of 1887, is also located at Huntersville.

Dr. George C. Battle, class of 1912, has resigned as assistant resident physician of the Municipal Hospital for Tuberculosis because of ill-health.

Dr. Dempsey William Snuffer, class of 1906, of Beckley, W. Va., has been appointed president of the board of health for Raleigh county, West Virginia, for a term of four years from September 1, 1912.

Dr. John Turner, Jr., class of 1892, has resigned as physician to the city employes at Loch Raven.

Dr. Ernest Zueblin, whose opening address to his students is published elsewhere in this issue, arrived in Baltimore on September 18 and spent the 19th in the University Hospital attending to patients.

Dr. Calvin Todd Young, class of 1903, of Plant City, Fla., was a delegate from Florida to the International Congress on Demography, held in Washington recently. Dr. Watson Smith Rankin, class of 1901, secretary of the State Board of Health of North Carolina, was also a delegate from North Carolina, and both he and Dr. Young availed themselves of the opportunity to slip over from Washington to visit their old friends at the University.

Dr. Howard Steele Holloway, class of 1903, formerly assistant resident physician at the University Hospital, has located at Chattahoochee, Fla.

The sophomore medical class has elected officers for the coming year as follows: President, Mark V. Ziegler of Maryland; vice-president, Franklin B. Anderson of Maryland; secretary, Michael J. Egan, Jr., of Georgia; treasurer, Bascom L. Wilson of North Carolina; sergeant-at-

arms, Lyle Leeland Gordy of Maryland, and historian, Dorsey Paul Etzler of Maryland. The honor committee consists of John Lowry of North Carolina, Harry Jesse Gilbert of New Jersey, Lyle Leeland Gordy of Maryland, Louis Diener of Virginia and Nevins B. Hendrix of South Carolina.

Dr. William Michel, class of 1912, will hold a German class during the coming year for the benefit of the resident staff of the University Hospital.

Among the recent visitors to the University Hospital were:

Dr. Charles E. Terry, class of 1903, of Jacksonville, Fla.

Dr. Norman S. Dudley, class of 1901, of Church Hill, Md.

Dr. L. M. Allen, class of 1896, of Winchester, Va.

Dr. J. Ernest Dowdy, class of 1909, of Winston-Salem, N. C.

Dr. William T. Rowe, class of 1890, of Meyersdale, Pa., had the misfortune to be thrown from his automobile on October 8 while returning home from the funeral of a brother physician—Dr. John S. Garman. Dr. Rowe turned aside to avoid crashing into a carriage ahead of him in which were attendants at the funeral, and his machine plunged over an eight-foot embankment. He was severely cut about the face.

The Baltimore *News* of September 25 gives rather an interesting account of the life of Dr. John Samuel Fulton, class of 1881, whose work in the International Congress on Tuberculosis and the International Congress on Demography is so well known. Of his life it writes:

"Though born in Ohio (in Fremont, in 1859), John Samuel Fulton was educated in Maryland, having received his bachelor of arts degree from old St. John's (1876) and his doctor of medicine degree from the University of Maryland. He is a loyal son of the State of his adoption, a fondness shown first of all by his marriage with a Maryland girl, Miss Nancy White of Salisbury, where he practiced as a young man, and by the pride he takes in his Maryland and Baltimore citizenship. It is said that he never misses an opportunity to register and vote, and keenly feels his

responsibility in all matters of public welfare. 'A good citizen' is the verdict of 'those who are familiar with the man and his work.

"However, his manifold duties as a 'public hygienist' have not interfered in the least with his responsibilities as a father. To his three sons, the eldest of whom has just received his bachelor of arts degree from the Hopkins, he is said to be a 'boy with his boys,' enjoying their sports and pleasures with the same zest and heartiness as if he were a college lad himself. He is equally devoted to his daughters, the eldest of whom graduates from Goucher this coming June. The sport he is most fond of is sailing. In fact, it is said he never will be old, because he always sees the happy side of things and generously makes allowance for shortcomings of the 'other fellow.'"

The *News* goes on, and in writing of the personal qualities of Dr. Fulton, quotes his secretary as follows:

"He is the kind of man who believes in giving every fellow his chance. He looks at humanity not merely as a man, but as a collection of individuals in which every allowance should be made for everybody.

"Maybe I could best illustrate that by a little incident that happened the other day. A letter came for Dr. Fulton from a woman way off somewhere and containing most unreasonable requests. Among other things she wanted all the literature of the Congress to be mailed to her free of charge, as she had not the money to pay for it. I called Dr. Fulton's attention to it, but in the great rush of our work put it aside, intending not to bother him with it again until later. The very next morning he asked me about it and told me to be sure to give that poor woman all she had asked for.

"As a Baltimorean you ought to know that he was one of the men who were chiefly responsible for getting up the big tuberculosis conference in Baltimore in 1904, just before the fire, and that for years he was the secretary of the Maryland State Board of Health."

And *The News* showed up the humanness of the man by asking him if he was not proud and happy over his work in Washington and receiving the answer, "Not half so proud as I am of that little senior of mine up at Goucher."

Dr. FitzRandolph Winslow, class of 1906, served as superintendent of the University Hospital during the absence of Dr. William J. Coleman upon his vacation.

Miss Esther E. Brewington, University Hospital Training School for Nurses, class of 1907, has been appointed assistant to Miss Rosamond Minnis, class of 1907, in the James Walker Memorial Hospital in Wilmington, Del.

Dr. Wallace Sellman, class of 1900, formerly of Fairmont, W. Va., has temporarily discontinued the practice of medicine.

Miss E. Janie Guerrant, University Hospital Training School for Nurses, class of 1904, who was operated upon recently in the University Hospital for an injury to her knee, is doing nicely.

Dr. George M. Settle of the Neurological Department has returned from a vacation, which he spent in Savannah and Jacksonville.

Dr. Gideon M. Van Poole, class of 1899, Major, Medical Corps, U. S. A., is stationed at Fort Washington, Md.

The sixth full-time man to be appointed in the University is Dr. Bert Jacob Asper, class of 1911, who will be instructor in pharmacology and clinical microscopy.

Dr. Frank Lynn, class of 1907, who has been visiting in Ohio, has returned home and resumed his practice.

The University building has been completely renovated. The laboratories which were built upon the surgical ward porch have been opened. One will be used by the visiting staff for special work and the other for the general routine work of the hospital. A new steam plant has been installed in Davidge Hall. The museum has been completely overhauled and the specimens so arranged that they can be used for teaching purposes. A terrazzo floor has been laid in the main hall of the University building. The old maternity building has been reconstructed and opened as an annex to the dispensary, and will be used by the medical department. The library will be



open four hours daily, from 12 to 4, instead of two hours, as heretofore.

Dr. Thomas Henry Legg, class of 1907, of Union Bridge, Md., was a recent visitor to the University Hospital.

Dr. Morris R. Bowie, class of 1908, of Somerset, Colo., who has been spending the summer in Scotland, is the guest of Dr. Albert Hyson Carroll, class of 1907, for a few days

Among the University alumni practicing in Florida are:

Bonifay—R. S. Maneely, class of 1904.

Citra—Robert Lawson Kennedy, class of 1910.

Daytona—James E. Rawlings, class of 1904.

Jacksonville—Samuel Gilman Glover, class of 1910, resident physician St. Luke's Hospital; Howard S. Holloway, class of 1903, Bay and Laura streets; Franklin Pierce Hoover, class of 1884, Mutual Life Building; Chas. L. Jennings, class of 1906, 332 W. Monroe street; Claude Joyner, class of 1888, 400 W. Ashley street; John Hartridge Livingston, class of 1878, 304 Newman street; Jas. D. Love, class of 1897, 501 Laura street; Robert Lee May, class of 1890, 17 W. Beaver street; Robert H. McGinnis, class of 1897, 501 Laura street; J. Denham Palmer, class of 1872, Doty Building; James B. Parramore, class of 1909, 412 E. Monroe street; Louis Stinson, class of 1911, 107 Ocean street; Charles Edward Terry, class of 1903, City Hall; Fred. J. Waas, class of 1905, 108 W. Adams street; George Walter, class of 1910, 131 W. Adams street.

Lake City—Abner J. P. Julian, class of 1883.

Lakeland—Cicero W. Love, class of 1902.

Lake Weir—Hugh W. Henry, Jr., class of 1891.

Lawtey—George W. Brown, class of 1889.

McIntosh—Adam Clark Walkup, class of 1909.

New Smyrna—William C. Chowning, class of 1904.

Ocala—Arthur L. Izlar, class of 1889.

Orlando—Sylvan McElroy, class of 1907.

Plant City—Calvin T. Young, class of 1903.

Quincy—Clyde C. Mack, class of 1904.

Sanford—Oscar Wentworth King, class of 1907; Samuel Puleston, class of 1902.

Tallahassee—Benjamin J. Bond, class of 1904; Fred Clifton Moore, class of 1903; Henry Edwards Palmer, class of 1892.

Tampa—Lester Julian Ebird, class of 1903, 495 Boulevard; Rollin Jefferson, class of 1903, 609½ Franklin street; J. Brown Wallace, class of 1897, 706½ Franklin street.

Dr. John Rawson Pennington, class of 1887, of 4620 Kenmore avenue, Chicago, Ill., presented a paper on the X-rays as an Aid in making Diagnosis of Conditions in the Rectum and Other Portions of the Large Intestine at the fourteenth annual meeting of the American Proctologic Society, held in Atlantic City, N. J., June 3 and 4, 1912. Dr. Pennington stated that "while the rectum is easily inspected by various specula, and the sigmoid is less readily accessible by the use of sigmoidoscopes, such as the one with insufflation devised by him, the colon is inaccessible and its exact position difficult to ascertain. Very often it is also difficult to determine and locate pathologic conditions in the large intestine.

"Until recently the means of diagnosis have been limited to those used in other portions of the alimentary canal, viz., inspection after dilatation of the bowel with air or water, palpation, percussion and trans-illumination. All of these are open to the objection that they are uncertain.

"The writer observed in the latter part of 1899 that by introducing some agent into the large bowel which would cast a shadow, the X-rays may become useful in making a diagnosis of conditions in the twin cavities. It is only recently, however, that such procedures have become of practical value.

"A bismuth meal is useful in diseases of the stomach or duodenum, the agent being suspended in milk, acacia water, thick soup or some similar vehicle.

"But for the large bowel the action of bismuth per os is very slow. One author estimates that it requires from 12 to 15 hours for the bismuth mixture to reach the ileo-cecal valve; about 24 hours to gain the transverse colon, and 36 hours to penetrate to the sigmoid. By the method advocated this is done, so to speak, instantaneously.

"Coming now to the technic: The patient's bowels are first cleansed by means of laxatives and injections. He is then placed in the knee-shoulder position, and from 25 to 30 ounces of the mixture used for casting the shadow injected into the large intestine. For this purpose the author uses an ordinary irrigator and a short rectal tip.

A long rectal or colonic tube for administering the injection is unnecessary. After the suspension is injected the patient lies on his right side for a few moments so part of the menstium may pass into the cecum. He is then placed in either dorsal or ventral position on the radiographic table and the picture taken."

Dr. Pennington is one of the best known of the University alumni. He takes a most prominent part in the work and meetings of the American Proctologic Society. He occupies the chair of rectal diseases in the Chicago Polyclinic and Hospital.

Among the University alumni practicing in Illinois are:

Cairo—Henry W. Wickes, class of 1892, Surgeon U. S. P. H. and M. H. S.

Charleston—Christopher C. Webb, class of 1881.

Chicago—Philip Adolphus, class of 1858, 1639 Washington Boulevard; Metellus R. Barclay, class of 1889, 838 N. Clark street; Perry L. Boyer, class of 1899, Captain M. C., U. S. A., Federal Building; John H. Chew, class of 1863, 1223 Astor street; Daniel David Coffey, class of 1903, 1347 Noble street; Lawrence De Lancy Gorgas, class of 1883, 1504 E. 57th street; Louis M. Maus, class of 1874, Colonel M. C., U. S. A., Central Division; Chas. W. Morrow, class of 1887, 6334 Monroe street; John Rawson Pennington, class of 1887, 31 N. State street; David Salinger, class of 1894, 31 N. State street; Oliver Tydings, class of 1877, 31 N. State street; Anthony Kimmel Warner, class of 1885, 1024 Belmont avenue; George Young, class of 1887, Surgeon U. S. P. H. and M. H. S., City Hall.

Collinsville—Lay Gordon Burroughs, class of 1906.

Fort Sheridan—Gideon McD. Van Poole, class of 1899, Major M. C., U. S. A.

Grand Tower—William Robert Gardinar, class of 1910.

Peoria—Leonard H. Spalding, class of 1869, 805 N. Jefferson avenue.

Sullivan—Geo. Brinton Kessler, class of 1890.

A portrait of Dr. James H. Jarrett, class of 1852, of Towson, Md., will be on exhibition at the meeting of the Baltimore County Medical

Association, October 16, 1912. Dr. William J. Todd will read a sketch of Dr. Jarrett's life, and the picture will be later presented to the Medical and Chirurgical Faculty of Maryland. Dr. Jarrett has practiced in Maryland for fifty years.

Dr. Lewis Mines Allen, class of 1896, of Winchester, Va., was elected secretary-treasurer of the Shenandoah Valley Medical Society at Harrisonburg, Va.

Dr. Ernest Seth Bulluck, class of 1911, of Wilmington, N. C., has been taking a post-graduate course in New York.

Mr. Howard E. Lecates of the Senior Class, who recently underwent an operation on the neck, is recuperating at his home in Delaware.

Dr. Melchoir Gist Cockey, class of 1879, of Salina, Kansas, was a recent visitor to Baltimore and to his former home in Cockeysville, Md.

Dr. Lawrence E. McDaniel, class of 1911, has been appointed resident physician to Blue Mountain House, Pen Mar, Md.

Among the recent visitors to the University Hospital was Dr. Thomas Malcolm Bizzell, class of 1908, of Goldsboro, N. C.

The class of 1908 of the Medical School will hold a reunion in Baltimore in May, 1913.

Miss Mary Louise Gephart, University Hospital Training School for Nurses, class of 1911, has resigned as superintendent of the Havre de Grace Hospital and has resumed private work.

Dr. William Turnor Wooton, class of 1899, of Hot Springs, Ark., was elected president of the Medical Association of the Southwest at the meeting held in Hot Springs, Ark., on October 10, 1912. Dr. Wooton has an office in the Dugan-Stuart Building in Hot Springs. The Medical Society of the Southwest was organized in 1905, and its membership is limited to members of the State societies of Arkansas, Missouri, Texas, Kansas and Oklahoma. The next meeting, at

which Dr. Wooton will preside, will be held in Kansas City in 1913.

Dr. William Cuthbert Lyon, class of 1907, has donated a chloroform bottle to the operating-room.

We are glad to announce that Dr. Joseph E. Giehner, class of 1890, who recently suffered a painful injury to his foot, necessitating amputation of a toe, has sufficiently recovered to resume his work. The injury was incurred on a motor-boat.

Dr. Hyman R. Wiener, class of 1912, of the Harrisburg Hospital, was a recent visitor in Baltimore, and took occasion while here to look up his old friends at the University Hospital.

Miss May Katherine Steiner, University Hospital Training School for Nurses, class of 1912, has been appointed assistant superintendent of the Annapolis Emergency Hospital. Miss Alice Frances Bell, class of 1907, is superintendent.

In reply to the letter of an alumnus, we beg to state that Dr. Howard T. Robinson, class of 1904, is located at Grantsville, Garret county, Md.; Dr. Oscar Wentworth King, class of 1907, is at Sanford, Orange county, Fla., and Dr. Claude J. B. Flowers, class of 1907, is at 1609 Market street, Harrisburg, Pa.

## MARRIAGES

Dr. George Wilmer Yourtree, class of 1902, of Burkittsville, Md., was married to Miss Laura Eleanor Hightman in St. Luke's Lutheran Church, Burkittsville, Md., on September 25, 1912, by Rev. Charles J. Hines. Miss Elizabeth Hightman was maid of honor, and Howard Yourtree, brother of the groom, was best man. Dr. H. W. Gray of Washington was an usher, and Misses Evelyn Yourtree and Ruth Shafer were flower girls. After a trip to Bermuda the couple will live at Burkittsville, where the groom has built up an extensive practice.

Dr. Howard J. Maldeis, class of 1903, was married to Miss Louise Cecil Watkins, a member of the 1913 class of the University Hospital Training School for Nurses on Saturday, September 7, 1912, at 11.30 A. M. at the residence of the

bride's father, Mr. W. Maurice Watkins, Kate avenue, Arlington. Rev. E. M. Heffer, pastor of Arlington Methodist Episcopal Church, officiated. The couple spent a honeymoon in the North, and returned in time for Dr. Maldeis to take up his duties at the University. They will reside on Kate avenue, Arlington, Md.

Dr. James Hugh Bay, class of 1908, of Havre de Grace, Md., was married to Miss Mary Barton Saulsbury, University Hospital Training School for Nurses, class of 1909, on Tuesday, September 10, 1912, at 4 o'clock, at the home of the bride's sister, Mrs. William G. Pugh, Govans, Md. Miss Saulsbury is a daughter of the late Dr. and Mrs. Thomas Bascom Saulsbury of the Eastern Shore. She was formerly superintendent of the training school of the Maryland Homeopathic Hospital of Baltimore. Dr. Bay is the son of Mr. and Mrs. Thomas A. Bay of Jarrettsville, Md.

The ceremony was performed by Rev. Dr. McMillan, pastor of the Govans Presbyterian Church, and was witnessed only by a few relatives and close friends of the couple. The parlor was beautifully decorated with golden rod and ferns. The bride wore a traveling suit of brown, with hat and gloves to match. A reception was tendered Dr. and Mrs. Bay immediately after the ceremony, and at 6 o'clock they boarded the Merchants & Miner's Line for a trip to Boston. They also visited Niagara and returned home via the Hudson. They will reside in Havre de Grace.

## BIRTHS

A son has been born to Dr. Dwight Gray Rivers, class of 1910, of Fort White, Fla., and Mrs. Rivers, formerly Miss Martha Venable Edmunds, University Hospital Training School for Nurses, class of 1910.

Dr. Emile Bonniwell Quillen, class of 1904, of Rocky Mount, N. C., and Mrs. Quillen, formerly Miss Leila Griffith Owings, University Hospital Training School for Nurses, class of 1905, have announced the birth of a daughter.

## DEATHS

It is with much regret that we announce the death of Mrs. Georgie Davis Knipp, wife of Dr. Harry Edward Knipp, class of 1887, of 1002 West

Landvale street, Baltimore, on October 14, 1912, of tuberculosis. Mrs. Knipp was the daughter of George H. Davis of Carroll county, and although there were three sons in the family, she bore her father's full name until her marriage. She was a graduate of the State Normal School, and taught for some years in Carroll and Baltimore counties. She was married to Dr. Knipp seventeen years ago, and was all of her life a great church worker. She is survived by her husband and a daughter, Miss Minna Knipp, and a son, George Adam Knipp, three brothers and four sisters. One of the brothers surviving is Dr. Charles R. Davis, class of 1890, of 923 North Carrollton avenue.

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Dr. Robert Morris Dawson, class of 1869, died at his home at Bay Hundred, Talbot county, Md., September 8, 1912, aged 73 years. He is survived by his wife. Dr. Dawson was born March 12, 1839, at Royal Oak, Talbot county, Md., the son of Major John Dawson. He was educated at the Maryland Military Academy and Fort Edward Institute, New York, and served in the Second Maryland Cavalry, C. S. A. After the war he entered the office of Dr. W. G. G. Willson of Easton, Md., and later matriculated at the University of Maryland, graduating in 1869. He practiced at Royal Oak for eight years, and later moved to Bay Hundred, where he continued his practice until recently. Dr. Dawson was also much interested in agriculture and owned a large farm which he personally conducted.

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Dr. James H. Butler, class of 1857, died at his home, 1507 Bolton street, on September 26, 1912, of apoplexy. Dr. Butler had not been well for several weeks prior to his death, but he spent part of each day in his office in the custom-house, and went as usual on the day of his death. He returned to his home for lunch about noon, and complained of not feeling well. He suffered the attack shortly after reaching his home, and a physician who was summoned said he died soon after having the stroke. Dr. Butler was born in Baltimore in 1836, and when quite young became associated with the banking-house of Samuel Winchester at Baltimore and North streets, later beginning the study of medicine in the office of the late Dr. Geo. W. Miltenberger. He entered the University and was graduated in 1857, and appointed resident physician of the University Hos-

pital, then the Baltimore Infirmary. At the death of Dr. Berwick B. Smith, demonstrator of anatomy at the University, Dr. Butler assumed his duties. During the Civil War he served as a surgeon in charge of the United States Army Hospital in Baltimore. In 1876 he ran for Congress, but was defeated by Thomas Swann. He then entered the customs service (1877), and was made examiner of drugs, holding that position until 1892, when President Harrison made him an appraiser at Baltimore. At the time of his death he was, in point of service, the oldest appraiser in the service. Dr. Butler was an active member of Associate Congregational Church, a member of Oriental Lodge of Masons and Beauseant Commandery of Knights Templar, and was a member of the board of managers of the Masonic Temple. He is survived by one daughter, Miss Mabel Butler, his wife, formerly Miss Kate Griffis, having died four years ago. He was buried from his home on Monday, September 30, services at the cemetery being conducted by Oriental Lodge of Masons. The honorary pallbearers were Gen. Thomas J. Shryock, John M. Carter, C. C. Isaacs, A. H. Fetting, William D. Waxter, Charles C. Homer, Jr., Harry A. Remley, George F. M. Hauck, Dr. Walter B. Platt, P. E. Tome, George Cook, William F. Stone, F. Holmes Hack, J. Carlisle Wilmer, J. J. Bell and John Straughn.

A local paper writes of Dr. Butler:

"Dr. James H. Butler, for 35 years connected with the United States Treasury Department, was buried in Baltimore last week with high Masonic honors. President Carter of the Veteran Association, of which he was a member, describes him as a man whose whole life, professional, official, as churchman, husband, father, Mason and friend, was one to be admired and emulated, and adds: 'As we journey along the highway of life we are often reminded of the casualties of battle. A moment ago we touched elbows with a companion and friend; noting the failure of contact and we turn to ascertain the cause. He has fallen, and the silent comrade at our side mutually affirms the lesson—in the midst of life we are in death.'"

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On September 30, 1912, Dorothy Whiting, infant daughter of Dr. John William Ebert, class of 1912, and Mrs. Ebert. Burial was in Winchester, Va.

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No. 9

## A SUMMER CRUISE ON THE SPANISH MAIN.

By RANDOLPH WINSLOW, M.D.

### 3. *The Panama Canal.*

Almost from the time that Balboa climbed the hill on the Isthmus of Panama and saw both the seas, separated by only a few miles of land, the conception of uniting the Atlantic and Pacific by means of an artificial waterway was entertained. Numerous suggestions were made by different persons at an early period. Angel Saavedra proposed to pierce the Isthmus of Darien in 1520, and Antonio Galvao suggested a canal across Panama in 1550. Simon Bolivar, President of Columbia, caused a crude survey of the Isthmus to be made in 1830, and the United States Government made complete surveys of the Panama and Nicaragua routes in 1872-1875. The vision was clear, but the time of its accomplishment was still far in the future. While the United States was negotiating with Columbia for permission to build the canal, the latter country awarded the franchise to a French company which, under the leadership of the distinguished de Lesseps, began work on a sea level canal in 1881. It was soon discovered that a sea level canal was not practicable and later the specifications for a lock canal were substituted. After the expenditure of a vast sum of money and the sacrifice of thousands of lives, the work was discontinued for lack of funds in 1889. In 1894 a new French company obtained a concession for 10 years, and work was continued in a desultory manner. The plans of the French engineers called for a canal 75 feet wide and 16 feet deep, and they actually completed some 15 miles of excavating at sea level, but made but little impression on the elevated and more difficult portions of the work. The French failed partly for

lack of efficient machinery, but chiefly on account of the pestilential diseases that caused a holocaust among their employees. The time for the completion of the canal, however, drew on apace, impelled by unexpected and irresistible events. As the discovery of gold in California was the direct cause of the building of the Panama Railroad, so the Spanish War is the immediate factor in the completion of the canal by the United States. The record-breaking voyage of the battleship Texas from San Francisco to Cuba during the Spanish-American War will be readily recalled, and this showed the necessity of a shorter means of transferring our warships from one coast to the other. The feverish haste in completing the waterway is due to the urgency of preparing for the national defense, rather than to the advisability of seeking new and shorter commercial trade routes. From both defensive and commercial aspects, however, the completion of the canal is a matter of the greatest importance. The canal will be about 50 miles in length from deep water to deep water. Beginning about three miles from shore a channel has been dredged 500 feet wide and 41 feet deep, and, discarding the completed French canal entirely, a new canal has been excavated, of the width and depth mentioned, to Gatun. The total length of the sea level portion of the canal on the Atlantic side is about 7 miles. At Gatun the great dam is thrown across the Chagres Valley, nearly  $1\frac{1}{2}$  miles in length and  $\frac{1}{2}$  mile in width at its base, and rising to a height of 115 feet above mean sea level. This dam impounds the waters of the Chagres River and converts an area of swamp and jungle into a lake 164 square miles in extent, with a depth of 85 feet. Ships approaching from the Caribbean are raised from sea level to the Gatun Lake 85 feet by means of three huge double locks, each 1,000 feet in length and 110 feet wide, and as tall as a six-story warehouse. The locks are constructed of

solid concrete, with a central wall dividing them into pairs. In both the middle and side walls are huge culverts as large as a railroad tunnel, through which water is allowed to flow into the lock chambers and to fill them gradually and quickly without the disturbance that would occur if they were filled by allowing water to rush in from the end. It will probably take about 15 minutes to fill or empty each lock. The locks are closed by great steel gates 7 feet thick, 65 feet wide and from 47 to 82 feet high. Intermediate gates are also placed in the locks in order to save time and water when small vessels are being passed through. There are also emergency contrivances to take the place of the usual

sage of the largest ships. In order to prevent too great a pressure of water, a spillway has been constructed, by means of which the excess of water may be allowed to escape. The lake extends from Gatun to Bas Obispo, a distance of 24 miles, with a channel varying from 1000 to 500 feet and a depth from 85 to 45 feet. At Bas Obispo the great Culebra cut begins, and extends 9 miles across the backbone of the Isthmus. This is the most difficult piece of engineering of the construction, as the crest of the hills had to be cut down from about 500 feet to 85 feet. The canal prison in this section has a bottom width of 300 feet and a length of 9 miles. The Culebra cut at its widest point is nearly  $\frac{1}{2}$  mile



WEST CHAMBER LOOKING NORTH PEDRO MIGUEL LOCKS, PANAMA.

gates in case of any accident to the latter. Ships will not be allowed to enter the locks under their own steam, but will be drawn through by electric locomotives in order to prevent accidents. Besides the Gatun locks, there are two others at Pedro Miguel and Miraflores, the former consisting of but a single pair and the latter of a double pair of chambers. Their construction and dimensions are similar to those at Gatun, and by their means ships are lowered on the Pacific side. The water for the canal is obtained from the Chagres River, which, during the dry season, is an insignificant stream, but in the wet season is a raging torrent. By means of the dam at Gatun the waters of this river are impounded into a lake already mentioned, which will furnish at all times a sufficient depth to permit the pas-

across. The soil and rocks seem to have but small cohesive properties here, and landslides are constantly taking place which cause much extra labor for their removal, and delay the opening of the canal. Since my visit, in July, several slides have occurred. In order to overcome this tendency to slide, the hill on both sides is being cut back on terraces at different levels, causing an appearance like gigantic steps. I was able to ride the whole length of the Culebra cut in a private railroad motor car and to get an accurate idea of the magnitude of the work, and to see the great steam shovels scooping out the sides of the hill, and the compressed air drills making holes in the rocks; while now and then explosions of dynamite would cause the earth to tremble and gave an impression of an artillery

engagement. The long trains of dirt cars were constantly coming and going, removing the debris to dumps, where low places were being filled in, or to Balboa, where the great causeway is being constructed between the mainland and the islands in the bay. The high level section of the canal ends at Pedro Miguel, where there is a dam and locks that lower ships 30 feet to the level of another artificial lake  $1\frac{1}{2}$  miles in length. The Miraflores locks, in two pairs, lower ships 55 feet to the Pacific sea level section of the canal, which is about 8 miles in length and terminates at deep water in the bay. Balboa is the Pacific entrance to the canal, as Colon is its Atlantic port. The tide on the Pacific side varies

saving of 9540 miles. In like manner, the distance from our east coast to points on the west coast of South America, Japan, China and the Philippines will be lessened by thousands of miles. While at Colon a large party from our ship took a launch up the canal to Gatun. The water in the harbor was rough and in the trough of the waves the boat would sink so low that nothing but the sky and sea could be seen, and this was on a clear, calm day. Going up the new American canal we turned into the French canal and passed up that waterway to the great dam. The French canal is not used, except to bring supplies to Gatun. Along the banks of this canal is an enormous amount of cast-off



CULEBRA CUT LOOKING SOUTH.

about 20 feet daily, while on the Atlantic side there is only from 1 to 2 feet variation, hence it will be much more difficult to maintain the necessary depth in the Pacific section than in the other sections. I have briefly described the canal from Colon to Panama, but have omitted any reference to the number of cubic yards of excavation or of the number of barrels of concrete used in the construction of the locks and dams as being too vast for the comprehension of the lay mind. It is supposed that the first ship will pass through the canal about a year from now, though it will not be opened officially until a later period. The time of passage through the canal will be from 8 to 10 hours. From New York to San Francisco, via Cape Horn, is 14,840 miles; via the canal the distance is 5,300 miles, a

machinery, dredges, steamboats and junk which is rusting and rotting and not worth breaking up and selling for old iron. Reaching Gatun, we viewed the locks, and then walked a mile along the crest of the dam to the spillway; the heat was not oppressive, though the humidity was unpleasant. There were over 30 feet of water in the lake, but it was interfering with work on the locks, so the spillway was open and the water was escaping. When the lake is filled, the sites of many of the towns along the canal will be covered with water, such as Gorgona, the seat of the immense machine shops; Matachin, and many others. The railroad formerly was located in the bed of the lake, but it has been reconstructed upon higher ground well above the level of the lake. Upon the completion of the







a good cosmetic as well as anatomical functioning result, and this endeavor has its influence upon popularizing the open method of treatment. Patients want to see their X-ray pictures, so that they can know that the ends of the bones are in apposition, and if after being discharged they find the ends not in apposition, they want to know why.

Our patients should be told what ultimate result to expect, and this result should not be overrated, for often perfect restoration to normal cannot be had.

This has been brought about through the X-ray. Individuals often go and have X-rays taken on their own accord, and have them interpreted. X-rays are sometimes taken for a purpose, such as to try and institute malpractice cases, increasing slight deformities, making them appear gross. This is not an uncommon thing to be done when suits are brought. I know of one case which was X-rayed many times at different angles, and the worst appearing deformity introduced in the suit as evidence.

We should remember that an X-ray should always be taken in two directions—at right angles to each other—to get the proper interpretation. I have seen a number of X-rays taken, one view showing a very good result apparently and another at a right angle showing overriding or great deformity. This is especially true in oblique fractures, and where there is a convexity or concavity in line of the rays. To interpret these skiagrams correctly it requires some study and experience, as well as a knowledge of osteology, including the development of the epiphyses.

There are certain conditions which make it impossible to have all of our fractures X-rayed,

while I admit it should always be done when possible; but when these conditions arise, such as fractured pelvis, thigh, etc., where one cannot get their patient to an X-ray or an X-ray be gotten to them, they should be treated in the manner that one is most certain will give the best results, and the most certain method is unquestionably the open method. I do not mean to advise the open method except under the most favorable circumstances, where one can depend upon absolute cleanliness in the strictest sense.

I am well aware that the use of the X-ray in routine fractures, especially in the country, is impracticable and even impossible in many cases, but that does not mean that one should not profit by what others have learned by the use of the X-ray.

Since Dr. Lane's excellent article on open treatment of fractures the profession has taken to this method without discretion, and many cases have been operated upon by men poorly equipped and qualified to do this work, and worse results gotten thereby than if the closed method had been adhered to. I have been unfortunate enough to have had several of these cases come under my care in the past few months.

As regards materials to be used for the open method in long bones, as a whole I prefer the metal plate and screws; I do not mean to exclude other devices, for there are conditions and places where the plate cannot be used and other methods more satisfactory used, such as nails, pegs, wire, screws, staples, etc. Bone clamps for holding the fragments until union of the bone and relaxation of the muscles is sufficient to keep them in their normal position by external support should be condemned, or any device which communicates

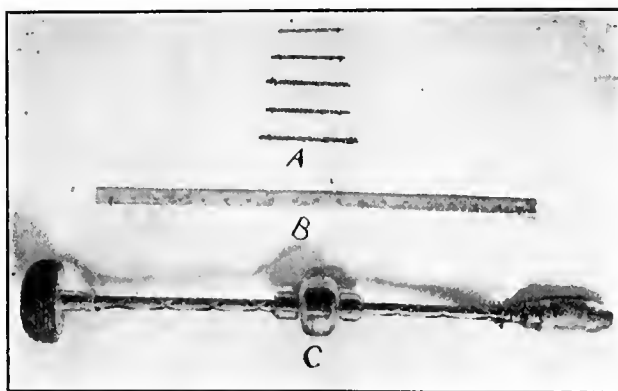


FIG. 1.

A represents the various sizes of drill points.

B, silver plate, the holes drilled, which may be cut the desired length.

C, ordinary carpenter drill (reciprocating), found most satisfactory in my bone work.

with the air, as there is great danger of infection, which it is practically impossible to prevent.

The plate which is shown in several of the cuts is made of silver, and varies in size. I have been using them for the past six or seven years. I had a quantity made with screw holes, as is shown in the Fig. 8; also screws, but the silver screws I discarded, and used the ordinary steel ones. The reason for discarding the silver ones was that they were too soft, and it was a common thing to twist off their heads. The plate, as you see, is quite long, and I cut it off the length that I desire; it is very pliable, and has this advantage over the Lane plate in that respect, and there is no chance of breaking or the screw holes breaking out on account of it being brittle. I have seen reports of this happening with the steel plate, but I understand now these plates can be had of some more pliable and softer material. The advantage of the pliable plate can readily be seen. It will give to a degree, and often will save the pulling out of the screws or breaking the plate.

The silver, and later bronze, wire which was so popular three or four years ago has been reduced very much in bone work since the plate method has become prevalent, and rightly so. While there are still many places where the wire has its use, such as patellar, olecranon and in comminuted fractures of long bones where there are many fragments and considerable of the shaft is involved, I wish to condemn the use of the wire for encircling long bones, as is often done in oblique fractures, for it may cause an amputation of the bone; especially this should be borne in mind in the treatment of children where there is much growth of the bone yet to take place. Dr. Blake of New York has recently reported an incident of this character. It is also a poor device to suture long bones with, for it allows too much motion, often causing bowing and displacement.

I have tried and own several drills, but the most satisfactory one is shown in Fig. 1, which I got at a hardware store. It is the ordinary two-way cutting carpenter drill, known as reciprocating drill, and the drill points, which can be had of any size, the regular steel bits. These bits can be improved upon; it is a disadvantage to have the thread the whole length, being much better to only thread it one-half inch from point, for if one is not careful the soft tissue in proximity with it will wind around when drilling,



FIG. 2.—Fractured femur with application of silver plate. Radiograph taken about 12 weeks after plate being applied.

which could not happen if the upper part of the bit were round and smooth.

To insure the best results in the open method of treatment in fractures the operation should be performed with neatness and dexterity, with the aid of proper instruments to insure as little trauma to the tissue as possible.

Dr. Joseph A. Blake has said what one surgeon may be able to do rapidly, accurately and cleanly would be impossible for another; so there are considerations to be taken into account other than the condition present in the patient. In fact, there is no province in surgery in which the result depends more upon the mechanical skill and cleanliness of the operator.

The majority of my plates have eventually come back to me for removal. While the operation of removal is trivial, the wound usually heals quite slowly; especially is this the case in the leg. The reason for this may be on account of the tendency to swelling, etc., after operations and injuries to these parts.

A point that has been brought very forcibly to my attention in several direct injury cases causing fracture is that they are very much slower in



FIG. 3.—Same as Fig. 2, but different view.

getting union than indirect injuries, and that there is a much greater tendency to bone death. Whether this is due to injury of the nerve or blood supplies I am not prepared to say, but am inclined to think that is the most probable cause. Crile has demonstrated in animals that fright and shock is a cause for delayed union. Mild infection does not seem to interfere with the healing of a fracture, but on the contrary seems to stimulate the formation of callus; but infection severe enough to cause necrosis of tissue manifestly will prevent union.

One of the greatest improvements toward the avoidance of infection is the improvement of our instruments. We now have devices for reducing fragments; also various bone clamps for holding the plate and fragments, and most of all, the traction devices, such as that devised by Ridlon of Chicago. The modification of his by Dr. Eikenbary of Spokane is the best one I have seen and one that I use, which is shown in Fig. 4. The great advantage of this in fractures of the lower extremity is that we can operate and apply our plaster without removing the stretcher, get any amount of traction, which is constant; also lessening the number of hands to

help, and there is no chance of breaking the plate or device used to hold the fragments while the external dressings are being applied, for this is quite liable to happen when held by hand. Our external dressings, whether plaster or what not, are the supports which have always been and are most relied upon now, even with our internal improvements, and should never be neglected.

If there was no danger or bad results connected with the open operation, it would unquestionably be the ideal method to treat all fractures. But it has been found that infection may take place, and an infection in a fracture is a compound fracture, for an open treated fracture is nothing more than that, and is always a serious condition, and has frequently led to the loss of limb, or even life.

Danger of primary wound infection has been eliminated in other operations, and there is no reason why it should not be done here, and this can only be achieved by the highest technical skill, for bone freshly opened seems to have less resistance to infection than any other tissue of the body. Lane of London has worked out this technic, and has shown us what good results can be had.

As regards the preparation for these operations, or any operation, soap and water has been relegated to the background for at least 12 hours. My routine for preparing the field for any operation is to have the part shaved, thoroughly washed with soap and water the night before, then washed with alcohol and allowed to dry; then a sterile towel is applied to the part, with no further preparation until the patient is placed on the operating table, where the operative field is swabbed off with benzoin or benzoin and iodine 1-1000 and allowed to dry, which removes the oil from the skin, and it is also a disinfectant; then apply a liberal coat of one-half strength tincture iodine with alcohol and allow to dry.

In compound fractures these wounds should not be washed with soap and water, as we did formerly, but the part shaved either dry, or use alcohol or benzoin to wet the part for shaving, and then apply the iodine. The gross dirt should be picked or trimmed away from the wound and part painted with iodine, the projecting bone fragments also painted, then allowed to dry before being returned. This method is much more simple and easier than the older methods, and very much more satisfactory.

I wish to take this opportunity to thank Dr. W. W. Potter for the excellent X-ray work he has done for me, some of which is shown here.

"Since writing this article I have been favorably impressed with Sherman's steel plate. They seem to fill the bill very satisfactorily, and have quite an advantage over the Lane plate and also over the silver plate that I have used so much, and recommend it in my article."

*Case I.*—White; male; age, 37. Was run over by a dirt car, causing a severance of all the extensor muscles of the anterior thigh and a compound fracture of the left femur. Patient was in extreme shock when he came under my care, and after waiting a short while, and by the use of stimulants, I was able to go ahead and sew the muscles together; put the patient up in long side splints with extension. This I kept on for about a week, but on account of the drainage it was necessary to remove the splint and apply a plaster one, so that I could get better access to the wound through a window in the cast. The wound remained open, and after the lapse of about 10 weeks I removed my plaster and found there was absolutely no union. When I opened down on the bone I found that necrosis of both ends had taken place, and it was necessary to resect the dead bone. Then I applied a silver plate with six screws, which is shown in Fig. 2. This patient made an excellent recovery, but has about three inches shortening.

*Case II.*—White; male; age, 23. Had a crushing injury to right leg, causing a compound comminuted fracture. His foot was also crushed, and it was necessary to remove four of his toes and one of the metatarsal bones. This was done some time after the accident, and the dorsal part of the foot was skin-grafted, as the skin was torn off from the upper part of the ankle clear down. I applied a silver plate with five screws. This patient made an uneventful and most satisfactory recovery.

*Case III.*—White; male; age, 46. Compound comminuted fracture of both bones of right leg. The injury was caused by direct violence, a heavy blow being received on the leg, driving out a piece of bone about two inches long from the middle of the shaft. This patient I operated upon immediately, found the proximal and distal fragments together, and the intervening piece driven out in the soft parts. By considerable traction I was able to separate the fragments

and work this intervening piece up into position, and applied a long plate with a screw in either end and one in the middle, which pulled up and held the intervening fragment in position.

*Case IV.*—White; male; age, 37. Had a crushing injury received to middle of shaft of left leg, causing a compound and much comminuted fracture of tibia and fibula. This case I operated upon immediately; found the bone for about six inches in the tibia comminuted and the fragments very much displaced in every direction. These fragments I molded into position and wired as best I could. This patient made an uneventful recovery, and is doing hard work, which requires the use of his leg all the time.

*Case V.*—White; male; age, 37. Engineer by trade; referred to me by the Drs. Abrams of Hill-yard; was shot accidentally by a .48-caliber bullet through the lower end of his humerus, bullet passing directly through the arm. This case I did not see until the day following the accident, and then reduced the fragments and secured them together with a steel peg and wires. This patient made an uneventful recovery, and is now working at his trade: has good motion, sufficient as not to interfere with his work, and I anticipate will eventually improve considerably over his present condition. He suffers no inconvenience whatsoever from the wire or from the steel peg in the bone.

*Case VI.*—White; male; age, 25. Has had a fracture of right radius, due to a direct violence blow. This fracture was put up in splints, and it was thought reduced, but upon taking an X-ray it was found there was considerable overriding, so the physician in charge attempted to reduce by the open method, and wired. The patient was then put up in splints and kept there for several weeks; the wound remained open, and after some time the splints were removed and an X-ray again taken. (I regret that I have not these X-rays to show, but I was fortunate enough to see them.) As the sinus persisted, the arm was again opened, wire removed, but the deformity was left.

This patient fell into my hands several weeks after this. He had a very limited motion and considerable ankylosis of his fingers, and almost complete ankylosis of the wrist, and was very much incapacitated thereby. I suggested to him the opening down and correcting the deformity, which he consented to having done. When I opened down I found the bone, with the distal end



FIG. 4.—Traction device as appears when applied to patient; it can be used either on one or both legs at a time, as is desired.

bowed out; it was with much difficulty that I was able to get it down in line with the approximate end, which I succeeded in doing by applying a plate. When a plate was taken, three weeks after the operation, it could be seen that the constant strain and pulling of the lower fragments had pulled the screws up a little. It was necessary to remove this plate, as a sinus persisted. This was done by my associate during my absence, about 10 weeks after the plate had been applied. At that time the patient was doing and had been doing splendidly, but after the removal of the plate for some unknown reason the patient was taken ill immediately, and died within the next few days from some rather obscure condition, it being possibly a septic condition, although the wound was laid wide open and packed at the time the plate was removed and no stitches taken. This is the first and only fatal case of this character that I have had. The bone was thoroughly united, and apposition, I am told, was excellent.

*Case VII* represents a man hurt in a wreck in which he had both legs fractured. I did not see him until about 10 weeks after his injury, and at that time he had an ununited fracture of his right leg, with a great deal of crepitus and a number of sinuses running pus scattered all along his mid thigh. An amputation had been advised, and he was sent here for that purpose.

After examining him I advised a resection and removal of about the middle third of his thigh bone, for it was very plain to see that the fracture was comminuted and a quantity of dead bone was present. The right leg was united.

On September 21, 1909, I opened and removed two large spicules and then resected both of the

ends of the femur. The bone removed was dead, and some of it had a worm-eaten appearance, showing absorption was taking place. Then I applied a silver plate with three screws below and two above. After a very protracted stay in the hospital he managed to get a good, useful leg, which he can walk about on very well, although it is about six inches shorter than it was before the accident; but he wears a high shoe on his foot and uses a cane. Fortunately, the other leg is about four inches shorter than it was formerly, on account of the overriding from the other fracture. This may be called a fortunate mistake.

In an X-ray taken shortly after the operation a slight bending of plate and a little displacement of ends is possibly due to the position in which it was put up following the operation, and the soft parts were puckered up in the middle thigh, which gradually contracted and took care of the slack.

I took an X-ray recently, two years and nine months after plate was applied. Recently a sinus which formed, healed and reformed two or three times, was responsible for my taking the last X-ray, which shows the middle screw in the lower fragment is loose and has worked its way almost out. I will remove the screw, but will not disturb the plate unless further trouble develops, which I rather think is doubtful, on account of the sinus healing up a couple of times previous.

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Dr. S. DeMarco, class of 1900, has returned from a hunting trip in the wilderness of Maine. He hoped to bring back a moose, a bear and several deer, but some of the boys "don't know yet what he got."

ADDRESS OF PROF. ADOLPH BICKEL  
OF THE UNIVERSITY OF BERLIN DE-  
LIVERED TO STUDENT BODY OF THE  
UNIVERSITY OF MARYLAND, OC-  
TOBER 5, 1912.

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It has been a great pleasure to me to be the guest of such an ancient and distinguished university. You may be interested to know that in a journalistic endeavor I have been associated with your professor of physiology for several years. For being the editor-in-chief of the *International Archives of the Pathology of Digestion and Metabolism*—I selected your Professor Hemmeter as my American editor after the death of Dr. Christian A. Herter of New York. But yesterday at dinner I discovered that Professor Hemmeter and I are fellow-alumni, for he studied at the same school, the *Königliches Realgymnasium* at Wiesbaden, which is my native city. So that I may claim a personal acquaintance with your teacher and in addition to this I am familiar to a limited degree with the educational and scientific history of the University of Maryland.

For wherever medicine has a student it is known that it was James Carrol who discovered that yellow fever is transmitted by the bite of a specific mosquito, and so heroically submitted himself to the bite of an infected mosquito, voluntarily made himself the object of experiment and suffered a severe attack of yellow fever, from which he later on died. To have produced such a brilliant discoverer and martyr to science is an achievement of which any university can be proud. It is known also that your alumnus Henry C. Carter led up to this great discovery by his thorough study of the extrinsic period of incubation of yellow fever. It may be said that the scientific work of Carrol and Carter on the etiology of yellow fever made possible the construction of the Panama Canal. And I congratulate the Regents of this University on having produced such an alumnus as Gen. Rupert L. Blue, who stamped out the bubonic plague from San Francisco, and now holds the highest medical office within the gift of the United States Government.

A well-known saying of the gospels is to the effect that "a prophet is not without honor except in his own country." From what I heard of your professors during my short trip in this

country, I know that they are considered most effective teachers; but it is to the department of physiology that your greatest reputation in Germany is due, for your professor of physiology has published some of his most brilliant research work in Germany, and I can assure you that the German Physiologic Society is proud of his membership and that nothing would gladden the hearts of the German confreres more than to hear that the Regents had more liberally endowed the laboratory of physiology—for from this source we may expect the most telling research work, especially in that specific domain, Physiology of Digestion, in which he is an authority of international reputation. Some of his discoveries have already been confirmed in my own institute.

I urgently recommend the encouragement of physiologic and pathologic research in this university, and with such able teachers as you are fortunate enough to possess this University cannot fail to rise to higher and higher standards.

May the interests of the University of Maryland be united to the noble purpose of higher medical education, so that it may resume a standard that is destined by Divine Providence.

Professor Hemmeter in introducing him said:

"While the Americans as a nation believe in high tariff, there is no tariff on intellect, and while the American people do not believe in monarchs, they are always glad to welcome the monarchs of science. The great physiologist, Ludwig, of Leipsig, once said to my teacher, Prof. H. Newel Martin: *All das Wasser welches uns trennt kann die Flamme der Bewunderung nicht löschen, die ich für Ihre rastlose Thätigkeit empfinde*, which means 'All the water that separates us cannot extinguish the flame of admiration which I feel for your wonderful and restless activity,' and these are the words that I feel are due in introducing to you Prof. Adolph Bickel, whose only address in America will be to you, my students."

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The Senior Class election of officers resulted as follows: Norbert C. Nitsch, president; Claudius A. Hayworth, vice-president; Frank P. Callahan, secretary; Elmer Newcomer, treasurer; Hamilton J. Shusher, chairman of executive committee; Earle Griffith Breeding, editor-in-chief. The remaining officers will be elected at some future date.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, NOVEMBER 15, 1912.

## STATUS QUO.

We are pleased to announce that, having complied with the New York rules in regard to six salaried, full-time instructors, as well as meeting their other requirements, the Medical Department of the University of Maryland has been registered for four full years by the educational department of the State of New York. This means that our graduates are eligible to appear before the Board of Examiners of New York, and, if successful in passing the examinations, they will be licensed to practice in that State. This is no empty honor, as there are many schools that are placed in class A by the American Medical Association that are not registered by the New York authorities, and whose graduates cannot practice in New York until they have taken an additional year in some other institution. Moreover, those schools that are registered cannot give advanced standing to the students of non-registered schools. As we have declined to give advanced standing to the students of some of these "accredited" schools, whom we formerly accepted, it is with great satisfaction that we are able to state that the enrollment of students for the present session is but little less than that of last year, and that the new men entering upon the study of medicine are of an exceptionally good class. The work of the session began promptly, and has been conducted with enthusiasm. The new men who are now filling their first terms of service with us are not only well qualified for their positions, but are proving themselves valuable acquisitions to the school. On the whole, then, we are well satisfied with the present status.

## SECURING FUNDS.

Some months ago the cry "On to Homewood!" resulted in bringing \$1,000,000 to a celebrated institution of this city. Within the past few weeks the threat that another institution would leave Baltimore and go to Chicago unless \$700,000 was raised in the city and State resulted in securing nearly half a million dollars for that institution. It is time for the University of Maryland to bestir itself and to adopt a slogan which the people will hear and heed: "Help us or we close." The closure of the medical and other professional schools of the University of Maryland, after an honorable and useful existence of more than 100 years, would also be a calamity to the city and State that they could ill-afford to suffer. We must have outside assistance in the near future or die of starvation. We believe we shall receive this assistance. In the meanwhile, let each alumnus contribute something to the pathological fund. We would like to have the department of pathology endowed by the alumni and largely conducted by them. At the present time the funds available for this purpose approximate \$20,000. We need \$100,000 for the department, and an endowed professorship of pathology could be founded for \$50,000. The additions to the fund in October were insignificant, but better than nothing.

### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	81 84
1873.....	441 83
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	250 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00

1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	115 00
1899.....	50 00
1900.....	215 00
1901.....	270 00
1902.....	330 00
1903.....	315 00
1904.....	135 00
1905.....	220 00
1906.....	175 00
1907.....	110 00
1908.....	20 00
1909.....	5 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

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Total subscriptions to Nov. 1, 1912..\$10,280.17

NEW SUBSCRIPTIONS IN OCTOBER.

Dr. N. S. Dudley, 1901.....	\$10 00
Dr. R. L. Felts, 1898.....	10 00
Dr. O. A. Howard, 1906.....	10 00
Total.....	\$30 00

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## CORRESPONDENCE

September 25, 1912.

To the Honorable, the Board of Regents of the University of Maryland.

*Gentlemen:*

The relations of modern universities to educational as well as social and economic progress are burning questions in our country just now. In respect to the organization of our universities, we have come to realize that the time is at hand when the average Medical and Law School, Dental College or School of Pharmacy ought not to struggle along trying to keep up a separate existence, since it can operate more effectively and with less expense under the aegis of a university.

"La union fait la force" is an adage that has almost universal application in successful organization.

One has but to point to the great strides made by Yale, Harvard and Columbia since they have

been permeated by the university idea, which represents organized co-operation.

It is an interesting fact that Maryland was quite in line with Northern States in this regard at the start, for the university idea was projected by the founders of Maryland in 1640, and even in 1784, as you know, the charter of St. John's College at Annapolis authorized it to enter into an alliance with a Maryland university. This, we have been told, was the dream of George Washington, a matriculate of St. John's.

But further, in 1812, history tells us that the University of Maryland was constituted as such by an act of the General Assembly which empowered the then College of Medicine of Maryland (chartered in 1807) to annex to itself other faculties, viz., those of divinity, law and the sciences in the city and "precincts" of Baltimore.

You are aware, however, that no such annexation took place, one reason being that the theological department never materialized. The provisions of the charter relating to such a department were seemingly impracticable. The departments of law and medicine, however, proceeded to operate together under the charter. Your body added the dental department in 1882 and in 1904 the department of pharmacy, which had for 60 years led a separate existence. I venture to recall these facts, as they have a bearing on the future of the University.

You have been successful for several reasons, and first, I believe, because you have taken care to secure sound and efficient teachers in your several departments; men who have realized their opportunities and responsibilities, and have had the practical experience necessary to make their teaching attractive and forceful. We all know that it is the quality of the teaching more than anything else that has enabled you to enroll more than 1100 pupils during the session of 1911-12. Teaching is an art not easily acquired. It is usually inborn. Many of the most learned and even the most distinguished men in professional life do not possess it. And yet it is essential in a successful teaching body. But you have been rich in achievements. Not to go beyond the limits of our own profession, the names of Nathan R. Smith and Elisha Bartlett would have shed luster on any institution. And, again, some of the most distinguished professors of medicine now in office in other universities were graduates of your old University. And you have been



pioneers. I am told that you were the first medical institution to introduce compulsory dissection of the human body. You were the first to put the teaching of hygiene and medical jurisprudence into the curriculum. You were also the first to make the teaching of the diseases of women and children the specialties that they are now.

Your progress has, however, been hindered by lack of funds and lack of appreciation on the part of the people of Maryland of what you have done and are doing.

The modern university, embodying as it does the highest ideals in education, needs and should have more general support than it has. In the medical department large sums are necessary to fulfill its requirements and the more active the movement in the direction of larger, more numerous and better equipped laboratories, the greater the progress that can be made, as we know, toward the ultimate eradication of disease. The department of physiology in the University of Maryland is liberally supplied with money, but other departments have not been so fortunate.

But to come to the question of the hour. Who is to be selected to fill the vacancy caused by the death of your late provost; a man who honored the University and was honored by his position, Bernard Carter, the able jurist and patriotic citizen, known for his rare ability as well as for his charming social qualities the whole length and breadth of our land? Whom will you now select to guide the destinies of your institution with dignity and success?

You will naturally have in view a representative man in touch with the university idea, with the education movements of the day and their leaders; a man also of attractive personality and ripe experience. I am unaware if the pecuniary stipend would justify the acceptance of the position by President Fell of St. John's College, nor am I qualified to represent him in any way; but it strikes me that inasmuch as he has put himself on record as favoring such an expansion of the institution as to include among its departments a school of technology, a school of music and a school of the fine arts, he can be said to have the University idea. His other qualifications speak for themselves. Respectfully yours,

THOMAS E. SATTERTHWAITTE,

A.B. (Yale), M.D. (Columbia), LL.D. (University of Maryland), Sc.D. (St. John's).

## ITEMS

Prof. Adolph von Bickel of the University of Berlin, who is the director of the Institute for Experimental Medicine associated with the University of Berlin, was the guest of Prof. John C. Hemmeter on October 4, 5 and 6, at his residence, 739 University Parkway, Roland Park.

Professor Bickel had been summoned to this country by Mr. J. Green, president of the National Biscuit Company, to treat Mrs. Green, who was suffering from pernicious anemia. He also attended the Congress of Hygiene and Demography at Washington. He is editor of several German journals and an investigator of rare ability. While in this country he delivered no other address except the one at the University of Maryland on October 5.

Kappa Psi Fraternity held an informal smoker at their new home, 242 W. Hoffman street, on October 9.

The Randolph Winslow Surgical Society is now upon a firm basis, and its members are looking forward to an exceptionally prosperous year.

Among the University alumni practicing in Idaho are:

Ilo—Joshua T. Price, class of 1868.

Weiser—Wm. M. Mitchell, class of 1905.

The following officers were elected by the Junior Medical Class: President, William S. Walsh; vice-president, James Furman Dobson; secretary, George Loutrell Timanus; treasurer, Clarence C. Hoke; historian, Alfred Mordecai.

The Phi Sigma Kappa fraternity have opened their home at 1222 Mt. Royal avenue.

Prof. A. M. Shipley gave an interesting address upon anti-vice at the smoker tendered University of Maryland students by Prof. Howard A. Kelly of Johns Hopkins Hospital.

The Latin-American Club, one of our most solid organizations, at a meeting held early in October elected the following officers: President, J. M. Buch, M., '13; vice-president, V. P. Rei-

necke, D., '13; secretary, Herman M. Perez, M., '13; treasurer, I. H. Fajardo, M., '13; historian, K. de Jongh, D., '13.

The Freshman Medical Class has elected the following officers for the coming session: President, Cecil Rigby; vice-president, E. L. Bishop; treasurer, G. B. Wilkenson; secretary, B. B. Brumbaugh.

Among the University alumni practicing in Delaware are:

Delmar—S. Howard Lynch, class of 1906.

Dover—Edward F. O'Day, class of 1890.

Georgetown—George Frank Jones, class of 1889.

Gumboro (R. F. D. Millsboro)—Oliver V. James, class of 1906.

Laurel—William Thompson Jones, class of 1895.

Middleton—Dorsey W. Lewis, class of 1896.

Reedy Island (Port Penn P. O.)—Lawrence Kolb, class of 1908, army surgeon, U. S. P. H. and M. H. S.

Wilmington—C. Anthony Beck, class of 1901, 1836 W. 4th street; Ira Burns, class of 1905, P. R. R. Station; Gerald L. Dougherty, class of 1908, 1901 Delaware avenue; Thomas H. Phillips, class of 1907, 624 N. Franklin street; William Marshall Priest, class of 1909, 8th and Adams streets; Meredith Ivor Samuel, class of 1900, 1016 Washington street.

Dr. Josephus A. Wright, class of 1881, has resigned as superintendent of Sydenham Hospital, and has been succeeded by Dr. Samuel T. Nicholson, a graduate of Hopkins in 1910. Dr. Wright succeeded Dr. Robert A. Warner, class of 1895.

The Baltimore and Ohio Railroad Company will build an emergency ward at the University Hospital within the next few months. It will be one of the best equipped and most modern in the city. Dr. Page Edmunds will be in charge when completed. The present ward H, on Greene street, will be torn down and remodelled at a cost of \$4500 to \$5000 to meet this new demand. There will be an operating-room completely equipped with all the necessary emergency instruments, a special room for the seriously injured and a sun parlor and room for the less

seriously injured. At present it is planned to have only those patients injured on the Baltimore and Ohio treated in this ward, and will be the only one maintained by the railroad company.

Prof. Randolph Winslow was given a surprise on Tuesday afternoon, October 22, when a reception was given in his honor by the resident physicians of the University Hospital in honor of his sixtieth birthday, which occurred on the following day, October 23. When he appeared before his class he was presented with a bouquet of 60 American Beauty roses, one for each year of his age. Dr. Winslow has taught at the university more than 39 years.

Dr. James B. Parramore, class of 1909, of Jacksonville, Fla., has decided to limit his practice to surgery and gynecology.

We wrote and asked Dr. Darius Cleveland Absher, class of 1909, of Mount Airy, N. C., to let us know what he had been doing since he left school. We think his reply is far better put than we could frame it, so we reproduce it for the benefit of our readers. He writes:

"I am willing to tell the little there is to tell, although I am sure it will not be interesting. The first thing I did after leaving the university was to 'go up against' the North Carolina Board, and I am glad to say they 'saw fit to let me by.' I then located at North Wilkesboro, N. C., and became associated as interne with a small private hospital (the Wilkes Hospital) for about 15 months, gaining some good practical experience, and at the same time I was engaged in some private practice and 'taking unto myself a better half.' In the fall of 1910 I went to New York, where I took courses in operative surgery at the New York post-graduate and at Bellevue, and attended clinics at several other hospitals in New York, Philadelphia and Baltimore. In January, 1911, I located in Mount Airy, doing general practice and some little surgery, and hold the position of municipal health officer. I am a member of my State Medical Society and of the A. M. A.—as I think every reputable physician should be.

"I am exceedingly glad to hear of the progressive steps the University of Maryland is taking—raise the standard higher, both in entrance requirements and in better teaching, so that every

alumnus of the old school may be able to point with pride to our old Alma Mater and her record—then every alumnus will be glad to stand by their Alma Mater and push her still higher, but then she won't need it so much. Now is her hour of need and I would that every alumnus would stand shoulder to shoulder, both financially and otherwise, in pushing the old university to the front and in making her the peer of any school in America. I long to see the day when the school will be in reality the State University of Maryland, and supported and made great as such.

"With greetings to all of the old boys, I am."

Dr. Absher served for one term as vice-president of his county medical society, and while at North Wilkesboro was secretary and treasurer of its county medical society, so he has not hesitated to give his time and work to the uplifting of his profession. His plea for the university is as timely as it is forceful, and we appreciate his spirit of love for his Alma Mater.

By request we give the following locations of the class of 1909:

Darius Cleveland Absher, Mount Airy, N. C.  
 A. Marvin Bell; address unknown.  
 George E. Bennett, 1127 Madison avenue, Baltimore.  
 Clarence Irving Benson, Port Deposit, Md.  
 William John Blake, Benwood, W. Va.  
 William Ward Braithwaite, Christobal, Panama.  
 Norman Irving Broadwater, Oakland, Md.  
 Maxey Lee Brogden, Swansea, S. C.  
 Paul Brown; address unknown.  
 Howard Barton Bryer, Newport, R. I.  
 Miguel A. Buch y Portuondo, Santiago, Cuba.  
 William S. Campbell, Albany, Mo.  
 Arthur E. Cannon, Clifton, S. C.  
 Arthur Judson Cole, Holbrook, Mass.  
 Clarence Bythell Collins, Calvert, Md.  
 Branch Craige, El Paso, Texas.  
 Carroll Augustus Davis, Arrington, Nelson county, Virginia.  
 Thomas Robert Dougher; died February 16, 1912.  
 J. Ernest Dowdy, Winston-Salem, N. C.  
 Arthur Louis Felsenfeld, Forest Park, Md.  
 Harry Baldwin Gantt, Jr., Millersville, Md.  
 Robert H. Gantt; died June 10, 1911.

Benjamin Harrison Gibson, 403 East Bolton street, Savannah, Ga.

William Thornwell Gibson, Batesburg, S. C.

Thomas Gilchrist, 1511 Green street, Philadelphia, Pa.

Julian Mason Gillespie, U. S. P. H. S., Honolulu, Hawaii.

Edwin B. Goodall, 98 Emerson street, Haverhill, Mass.

Morris Baldwin Green, Hamilton, Md.

Jose Y. de Guzman, Soto, Porto Rico.

Simon Wickline Hill, Regent, N. D.

Joseph Ward Hooper, James Walker Memorial Hospital, Wilmington, N. C.

James A. Hughes, Strong, Pa.

Preston Hundley, Montross, Va.

Everette Iseman, 11 East Jones street, Savannah, Ga.

George Edward James, Newport, N. J.

Charles Herbert Johnson, 714 Linden street, Camden, N. J.

Adam Seanor Kepple, Hannastown, Pa.

Howard Kerns, Granite Falls, Minn.

William Walter Kettle, 714 Glesian street, Portland, Ore.

Ralph Norvel Knowles, Hebron, Maine.

Edgar Miller Long, Hamilton, N. C.

Samuel Herman Long, 1922 East Baltimore street, Baltimore, Md.

Ross Simonton McElwee, Statesville, N. C.

James Finney Magraw, Perryville, Md.

William E. Martin, Roslyn, Md.

John Sanford Mason, Whiting Block, Albuquerque, N. M.

James William Meade, Jr., Fishing Creek, Md.

John Lindsey Messmore, Masontown, Pa.

Cieland G. Moore, Schuyler, Neb.

James Leftwich Moorefield, Guilford College, N. C.

Charles A. Neafie, Blackwell's Island, New York, N. Y.

John Standing Norman, Bladenboro, N. C.

John Nelson Neill Osburn, Martinsburg, W. Va.

James B. Parramore, Jacksonville, Fla.

Lytle Neal Patrick, Gastonia, N. C.

Thomas Alexander Patrick, Fayetteville, Tenn.

Samuel Jackson Price; address unknown.

Wilmer Marshall Priest, Wilmington, Del.

Lynn J. Putnam, Shenandoah, Iowa.

William Gwynn Queen, Arlington, Md.

Fred Wharton Rankin, North Carolina.

Jemil Abdallah El Rassy, Syria.  
 Joel Cutchins Rawls, Franklin, Va.  
 Budd Jameson Reaser, Martins Creek, Pa.  
 J. W. Ricketts, Central avenue and 32d street,  
 Indianapolis, Ind.  
 John William Robertson, Onancock, Va.  
 Harry M. Robinson, 2010 Wilkins avenue, Bal-  
 timore, Md.  
 Louis Hyman Roddy, Cameron, Texas.  
 John T. Russell, Eastport, Md.  
 John G. Schweinsberg, 1120 West Cross street,  
 Baltimore, Md.  
 Andrew John Shakhashiri, Syria.  
 Reed A. Shankwiler, Detroit Tuberculosis San-  
 itarium, Detroit, Mich.  
 Furman Thomas Simpson, Westminster, S. C.  
 Hugh W. Smeltzer, Greendale, Va.  
 Claud C. Smink, Lauraville, Md.  
 Maurice Isaac Stein, 531 Cumberland street,  
 Baltimore, Md.  
 Neal Summers Stirewalt, McConnellsville, S. C.  
 Charles Franklin Strosnider, Newbern, N. C.  
 Charles LeRoy Swindell, Black Creek, N. C.  
 Asa Thurston, Taylorsville, N. C.  
 Alfred Chase Trull, Haverhill, Mass.  
 Frederick Henry Vinup, 1221 Hollins street,  
 Baltimore, Md.  
 Adam Clark Walkup, McIntosh, Fla.  
 John Bruce Weatherly, Altamahaw, N. C.  
 Walter Franklin Weber; address unknown.  
 T. Hayne Wedaman, Pomaria, S. C.  
 Lehman W. Williams, Statesboro, Ga.  
 R. Gerald Willse, 1127 Madison avenue, Balti-  
 more, Md.  
 Eugene Bascom Wright, Hebrew Hospital,  
 Baltimore, Md.

The following resolutions were adopted and ordered spread on the minutes of the Anne Arundel County Medical Society at their regular meeting held at Annapolis, Md., Tuesday, October 8, 1912:

*"Resolved,* Whereas God, in His infinite wisdom, has chosen to remove from our midst our friend and fellow-practitioner of medicine, Dr. Henry Roland Walton (University of Maryland, class of 1850):

*"Resolved,* That the Anne Arundel County Medical Society extend the family of our deceased friend and fellow-practitioner, Dr. H. Roland Walton, their heartfelt sympathy in their hour of affliction;

*"Resolved,* That a copy of these resolutions be forwarded to the family of the late Dr. Walton.;

*"Resolved,* That a copy of these resolutions be published in the official organ of 'The Medical and Chirurgical Faculty of Maryland;'

*"Resolved,* That a copy of these resolutions be published in the *Maryland Medical Journal*;

*"Resolved,* That these resolutions be entered upon the minutes of this meeting, held the eighth day of October, 1912."

Respectfully,

LOUIS B. HENKEL, JR.,  
 Secretary.

Dr. Arthur Dean Bevan of Chicago was the guest of Dr. Randolph Winslow on November 7, and while here was entertained in the University Hospital, where he met representatives from both the Baltimore Medical College and the College of Physicians and Surgeons of Baltimore.

A called meeting of the executive committee of the University of Maryland General Alumni Association was held at the office of Judge Dawkins on October 11, 1912. The following were present: Dr. Charles E. Sadtler (1873), president; James W. Bowers, vice-president; Hon. Walter I. Dawkins, Frank V. Rhodes, John B. Thomas, Eugene W. Hodson, John H. Skeen and Dr. H. F. Gorgas. Dr. Nathan Winslow was nominated for corresponding secretary for the coming year, nominations to be presented to the meeting of the Association on Academic Day, November 12. The directors nominated from the medical school were Drs. St. Clair Spruill (1890) and Harry Adler (1895). New members were nominated for the Advisory Council, Drs. Charles E. Sadtler (1873), E. F. Cordell (1868) and Harry Adler (1895) being nominated to represent the medical school. The nominees were elected at the meeting on November 12 immediately preceding the annual banquet.

Academic Day, November 12, 1912, marked the one hundred and twenty-third anniversary of the founding of St. John's College, the department of arts and sciences of the University. At 10.30 o'clock the formal exercises began at Westminster Church, Fayette and Greene streets, the St. John's Cadets, the University faculty and students and alumni marching in a body to the church, lead by the St. John's Band. The academic march—"The

University of Maryland"—was given on the organ by Robert L. Haslup, and the invocation delivered by Rev. Dr. Thomas Grier Koontz, pastor of the church. The acting provost, Judge Henry Stockbridge, made an address of greeting, followed by an address on the life and work of Bernard Carter, Provost, and by Arthur George Brown, and a similar tribute to John Wirt Randall, also a former provost and who also died during the year, by Philemon H. Tuck. Dr. B. Merrill Hopkinson, Messrs. Edgar T. Paul, Hobart Smock and John H. Richardson rendered solos during the meeting. Dr. Ernest Zueblin made an address on "Aims of Clinical Teaching," and referred to the "martyrs" of the profession who had given their lives in order to advance medical teaching. Dr. Zueblin paid a high tribute to the medical men of America, and said that their progress was being watched the world over, and that workers everywhere are stimulated by the achievements in medicine in America.

It was announced on Academic Day that Prof. and Mrs. John C. Hemmelter had made a gift of securities to the amount of \$5000 to be applied to the fund to support the Hemmelter chair of physiology, bringing the amount of the endowment up to \$10,000.

Among the recent visitors to the University Hospital were Drs. James B. Parramore, class of 1909, of Jacksonville, Fla.; Watson Smith Rankin, class of 1901, of Raleigh, N. C.; Brooke L. Jamison, class of 1905, of Emmitsburg, Md., and Thomas Brooks, class of 1910, of Santiago, Cuba.

#### ATHLETICS.

A call for football practice was issued by Coach Willse and was answered by a large squad, representing practically every department. The following dates were announced:

Oct. 26—Cross-Country Club. At home.

Oct. 19—Maryland Agricultural. At College Park.

Nov. 2—Open. At home.

Nov. 9—University of Pittsburgh. At Pittsburgh.

Nov. 16—Delaware College. At Delaware.

Nov. 23—St. John's. At Annapolis.

Nov. 27—Rock Hill. At home.

The Cross-Country Club game, although not an A1 exhibition, showed excellent material, which after a little practice should develop a bright future.

The lineup for the game was as follows:

F.B.....	Collison (captain).
R.H.B.....	Cooley, Krantz.
L.H.B.....	Ross.
Q.B.....	Anderson.
C.....	Stephens (manager).
R.G.....	Bowie.
L.G.....	Blackmore.
R.T.....	Kennard.
L.T.....	Dorell, Bung.
L.E.....	Rogers.
R.E.....	Murrey.

Manager H. H. Warner issued a call for basket-ball practice, which was answered by 15 men, but two of the old men turning out—Warner and Porter. A cracking good schedule will be announced, including Loyola, University of Pittsburgh, Catholic University, Carlisle, St. John's and others.

Academic Day was November 12, 1912. Professor Zueblin delivered the principal address.

Among the University alumni practicing in California are:

Bakersfield—Byron Rees Rees, class of 1900, Old Fish Building.

Chico—Oscar Stansbury, class of 1873.

Danville—H. C. Reamer, class of 1885.

Los Angeles—Chas. Lewis Allen, class of 1887, Pacific Electric Building; Frederick S. Cate, class of 1898, Nadeau avenue; Josiah Evans Cowles, class of 1880, American Bank Building; Roy S. Lanterman, class of 1893, Grosse Building; Joseph A. Le Doux, class of 1889, McLaughlin Building; Wm. K. Robinson, class of 1893, 610 S. Broadway; Benjamin Mosby Smith, class of 1888, 314 W. 64th street.

Since the advanced preliminary requirements have gone into effect, Dr. Coale informs us that of about 165 registered by the special examiner of the State Board of Medical Examiners, Mr. Otis, the University of Maryland has matriculated 93, or more than half of the total number.

Among the University alumni practicing in Massachusetts are:

Ashfield—John Edwin Urquhart, class of 1883.

Athol—George J. Bassow, class of 1899.

Boston—Wm. Thomas Councilman, class of 1878, 240 Longwood avenue; Richmond Favour, class of 1904, 2121 Washington street; Henry P. Frost, class of 1889, Boston State Hospital; Woodbury Dudley James, class of 1881, 82 Warren street; Chas. Lusby Pearson, class of 1883, 427 Marlboro street; Isaac J. E. Shapira, class of 1897, 238 Huntington avenue; Harold Walker, class of 1871, 147 S. Huntington avenue; James Homer Wright, class of 1892, 95 Mountfort street.

Brookline—Arthur Alden Cushing, class of 1904, 108 Marion street.

Fall River—Clarence W. Stansfield, class of 1906, 1274 N. Main street.

Foxboro—Irwin Hoffman Neff, class of 1889.

Haverhill—Alfred Chase Trull, class of 1909, 48 White street.

Holbrook—Arthur Judson Cole, class of 1909.

Holyoke—John Joseph Carroll, class of 1905, 120 Chestnut street; George L. Kinne, class of 1887, 265 Maple street; Harold E. Miner, class of 1905, 51 Maple street; Allen T. Moulton, class of 1911, interne House of Providence.

Lawrence—Walter Daniel Riordan, class of 1903, 187 Newbury street; Myer Schwartz, class of 1902, 261 Common street.

Lowell—Charles Ephraim French, class of 1893, Runels Building; Arthur E. Gillard, class of 1887, 32 John street; Frederick Augustus Warner, class of 1873, Lowell General Hospital.

Lynn—Elias Nathanson, class of 1908, 242 Summer street.

Northampton—Garrett J. Hickey, class of 1893.

North Attleboro—Amzi Beddell Shoemaker, class of 1908.

Southbridge—William Stanislaus Conway, class of 1910.

Swampscott—Edward Van D. Bray, class of 1894.

West Medway—Samuel Butler, class of 1904.

held for the visiting members of the fraternity at the University Hospital and Johns Hopkins on Saturday, November 30.

We regret exceedingly to announce that Dr. John Clements Harris, class of 1862, of 773 West Lexington street, was stricken with paralysis on the afternoon of October 31, and his condition is serious. Dr. Harris has been living for years alone in the big house on Lexington street and was found there alone and unconscious. He was taken to a neighboring residence and his only relative, a brother, James S. Harris, of Everett, Kent county, Maryland, was notified.

## ENGAGEMENTS

The engagement is announced of Dr. Elijah Emera Nichols, class of 1911, of Pikesville, Md., to Miss Caroline Estelle Lauer, daughter of Mrs. Henry Lauer, of Walbrook. The wedding will take place in the early spring.

## MARRIAGES

Dr. Herbert Jerome Rosenberg, class of 1908, of Atlanta, Ga., was married to Miss Rosalie Loeb, daughter of Mr. and Mrs. Marcus Loeb, Tuesday, November 5, 1912. The ceremony took place at the home of the bride, 439 Washington street, Atlanta, and was performed by Rev. Dr. Marx. After a honeymoon spent in the North, the couple will live at 409 Washington street, Atlanta, where the Doctor is engaged in the practice of his profession. Dr. Rosenberg is the son of Mr. and Mrs. A. Rosenberg of Greenwood, S. C.

Mrs. Sovenia Jane Smith has announced the marriage of her daughter, Miss Maude Fowble Smith, University Hospital Training School for Nurses, class of 1908, to Mr. Thomas Reese Cornelius, on Saturday, October 26, 1912, at Trinity Church, Towson, Md. Mr. and Mrs. Cornelius will be home after December 1, 1912, Giddings avenue, Govans, Md.

## DEATHS

Dr. Robert Ferguson Chapman, class of 1865, who has been in active practice for almost 50 years, died on the morning of November 12, 1912, at his home, 121 West 120th street, New York. Dr. Chapman was born in La Plata, Md., July 24,

The Nu Sigma Nu Fraternity have opened their new home at 618 West Lombard street, where they are preparing for the bi-annual convention of the fraternity to be held in Baltimore November 29 and 30. Special clinics will be

1841, and was the son of Gen. John Chapman and Susan Pearson Chapman, and was descended on both paternal and maternal side from the early English and Scotch settlers of Maryland and Virginia of 1633 and 1635. He studied at Charlotte Hall Academy, and later graduated at Yale with the class of 1862, being the only Southerner in the institution at the time of his graduation. He received his A.M. from Yale in 1865. He studied medicine for a while at the College of Physicians and Surgeons of Columbia University, and then Matriculated at the University of Maryland, graduating in 1865. He settled in Southern Maryland and practiced there for a while, moving to New York in 1872. On July 12, 1870, Dr. Chapman married Miss Nannie Duvall of Baltimore, who died two years ago. He was a member of the Psi Upsilon fraternity of Yale and of St. Andrew's P. E. Church of New York. Dr. Chapman is survived by one son, Robert Fendall Chapman, of New York, a graduate of the College of Physicians and Surgeons of Columbia University of the class of 1895.

Dr. J. Denham Palmer, class of 1872, of Jacksonville, Fla., died on November 3, 1912, from the effects of a bullet wound accidentally received. Dr. Palmer was in his offices in the Doty Building and had as a patient a young man who lived some distance from the office, and who carried the pistol as a method of protection because of the present unrest in Jacksonville. After Dr. Palmer had finished his examination the patient drew his coat across the table to put it on and the pistol was thrown to the floor. It struck at such an angle that the instant discharge sent the bullet into Dr. Palmer's thigh, from whence it glanced upward through his body. Dr. Palmer was rushed to St. Luke's Hospital instantly, this being about 2 P. M., but he died at 7.30 P. M.

Dr. Palmer was born in Monticello, and belonged to one of Florida's oldest and most aristocratic families. He attended the public schools of Florida and then matriculated at the university, from whence he was graduated in 1872. He practiced in Fernandina until 1905, when he removed to Jacksonville. He did yeoman service in the work of conquering and stamping out yellow fever during the epidemic in Jacksonville, Memphis, Tenn., and Fernandina, Fla. He was respected and loved by all, and the medical fra-

ternity throughout the State received the news of his death with the utmost sorrow. He is survived by three sons and three daughters.

## BOOK REVIEWS

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Lectures; Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology and Other Topics of Interest to Students and Practitioners. By leading members of the Medical Profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. With the collaboration of John A. Witherspoon, M.D., Nashville, Tenn.; William Osler, M.D., Oxford; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; Charles H. Mayo, M.D., Rochester; Thomas H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harrold, M.D., London; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipzig, Brussels and Carlsbad. Volume III; twenty-second series; 1912. Philadelphia and London: J. B. Lippincott Company. Cloth; \$2 net.

Prof. Theophilus Ciesielski in his paper, "How It Happens That the Offspring of Plants, Animals and Men is Sometimes Male, Sometimes Female," opens the old, old question; the riddle of many ages. He states: "After studying, year by year, from 1871 onward, the question of the origin of sex in *cannabis sativa*, I discovered in 1878 an unchanging and settled law of nature, in accordance with which it happens that sometimes male *cannabis* plants and sometimes female ones are produced, so that if we keep the law clearly in view we can in very simple fashion control this enigma of nature. For 33 years I have hesitated whether I ought to publish this law of nature; for I feared that the knowledge of it would tend to lower the moral standard, but now at length I am satisfied that I ought not to delay, for it may well happen that someone else may not hesitate to make this same discovery public."

Whether the conclusions drawn are true or not, the article shows the result of careful, painstaking, scientific investigation extending over a number of years, and that the theory is not hastily concocted. After years of experimentation upon the cannabis plant with ineffectual results, Dr. Ciesielski noted finally that female plants impregnated with fresh pollen produced male plants; female plants dusted with stale pollen produced female plants. Not satisfied that he had entirely solved the question, the author also investigated the problem in animals with the same results. He noticed that a doe rabbit served once only by a buck, which had not had connection for some days, produced a litter of two or three females, but if a buck was used which had had connection the day before, then she would bear two or three males. He states that he has proved the truth of this law in horses, dogs, cattle and man.

If the observations prove true, the author has made the world his debtors. At any rate, true or not true, his labors should be an incentive to others not alone in this field, but also in every line of medical research. It is, indeed, a rarity that we see a man in these times holding back any investigation and testing its value over such an extended period of time. Another paper well worth while is "The Modern Treatment of Gout," by Marcel Labbé, M.D. "The Diagnosis and Treatment of Locomotor Ataxia," by William J. Maloney, should interest the readers of the "Clinics." Besides the articles mentioned above, there are a number of others which concern pertinent topics of the day. Taken all in all, the present number is the best résumé of modern problems in medicine.

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INTERNAL MEDICINE. By David Bovaird, Jr., A.B., M.D., Assistant Professor of Clinical Medicine in the College of Physicians and Surgeons of Columbia University, Associate Visiting Physician of the Presbyterian Hospital and Visiting Physician of the Seaside Hospital in the City of New York. With 109 illustrations in the text and seven colored plates. 1912. Philadelphia and London: J. B. Lippincott Company. Cloth, \$5 net.

One is surprised that after extracting the material of the specialties, so much still remains

which may be delegated to the domain of internal medicine. Still it seems highly improbable that this divorcing can or will be followed much further. The tendencies of the times should be and no doubt will be the restoral of much to internal medicine which has been turned over to the specialties. However, even with the present and past aggressions, there is yet enough left to demand serious attention. In fact, internal medicine is the framework upon which the student builds his knowledge of the entire field of medicine, and if he is not well-grounded in its essentials, he will always be handicapped in his after work. With the numbers of good practices of medicine on the market, another would seem worthless, and at first glance the reviewer would coincide with this view. Writing a book for students, however, is a difficult task, and most of the books on the market are either too cumbersome for their purposes or too skimpy. What students desire is an authoritative book, devoid of statistical compilations and debatable theories. They desire facts stated dogmatically. If the subject under discussion is dealing with debatable matter, they desire the most likely hypothesis and nothing more. Such a volume is Bovaird's "Internal Medicine." It covers the field thoroughly and in a most satisfactory manner. We are particularly impressed with the manner in which the writer approaches the handling of matter which other authors take for granted is known; for instance, the minute and detailed manner in which he describes the technic of paracentesis. We are also gratified to note the number and quality of illustrations included in the text; a feature only too much neglected by most writers on internal medicine. Mechanical aids in the study of disorders of the circulation have become so perfected that every student before graduating should be absolutely conversant with the use of the various appliances. A chapter on this subject should interest students in the knowledge to be thus obtained. Syphilis, as it rightly should, has been included among those diseases due to animal parasites. Taken all in all, the book is admirably adapted to student purposes, being extremely well proportioned, neither too fulsome nor too meager. Its many good qualities should command it an early popularity.



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No. 10

## LEND A HAND

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- ¶ Many have, don't you also wish to?
- ¶ If you haven't contributed, a subscription will be greatly appreciated.
- ¶ Large contributions make the work swifter; small contributions gladden the hearts of the workers; all help in making the Pathological Department Endowment possible.
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“Look up and not down,  
Look forward and not back,  
Look out and not in;  
Lend a hand!”

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AN ACCOUNT OF SUBSCRIPTIONS TO DATE WILL BE FOUND ON PAGE 194

## A SUMMER CRUISE ON THE SPANISH MAIN.

By RANDOLPH WINSLOW, M.D.

### 4. COSTA RICA AND SANTIAGO DE CUBA.

One's preconceived ideas of geography are apt to be very much upset by actual travel. I had supposed Costa Rica to be situated due north of Colon; but, as a matter of fact, one sails almost due west to reach Port Limon, the only seaport on the Atlantic side of this Central American republic. Leaving Colon at 2 P. M., we reached Port Limon about 8 o'clock the next morning.

Having been duly lined up and examined, and found free of cholera, yellow fever, smallpox and bubonic plague, we were permitted to tempt fate by jumping into a rowboat when it rose on the crest of a wave and rowing ashore. Port Limon is an unattractive town of 5000 inhabitants. There is a small but pretty park, with the customary bandstand in its center. The houses are mostly of frame construction, and are not ornamental. The United Fruit Co. is the most important factor in the life of the town, and, indeed, in the financial and commercial affairs of the country. This company maintains good lines of steamships plying between New Orleans and Costa Rica, as well as between New York and Port Limon. The



PUNTARENAS, COSTA RICA.

Some ships put in at Bocas del Toro, which is a thriving town at the extreme northern part of Panama, to load bananas, but our itinerary did not call for a stop at that place. There is no harbor at Port Limon, but an open roadstead, which is both uncomfortable and dangerous. Ships can dock at the piers in good weather, but during storms they must cast loose and put to sea or seek protection behind an island. Fortunately, we were favored with fairly pleasant weather, though the water was by no means smooth. As much formality is observed on entering port in one of these bantam republics as is customary in the large seaports of the Great Powers. The flag of the country is run to the head of the foremast, and when the quarantine and customs officers approach the band plays the national hymn of the country.

banana trade is almost entirely in the hands of the United Fruit Co., though the Atlantic Fruit Co. also exports this fruit in smaller quantities. Costa Rica is a mountainous country of 23,000 square miles area, with a population of 390,000. The inhabitants are less mixed in character than are those of the other Central American countries, and are mostly of pure Spanish origin. On the coast there is a considerable number of West Indian negroes, who are in the employ of the fruit companies, but in the interior the people are white, with some admixture with Indian blood. Landing at Port Limon, and passing inspection, the next thing to do is to get American money changed into that of Costa Rica. The colone is the national unit of currency, being equivalent to about 44 cents in our money. A narrow-gauge railroad

runs from Limon to San José, the capital, about 103 miles, but only one train leaves daily from each terminus. For the first 20 miles the road traverses a flat, jungle-covered, swampy region, sparsely settled with negroes, whose shanties are collected here and there into miserable-looking villages. The negroes appear to be the same happy-go-lucky people that we find in our own Southern States, and here and there they were seen dancing and making merry to the music of some broken-down instrument. Soon we were ascending the mountains, ever increasing in altitude, until 6000 feet is reached. The ride over the mountains is very beautiful. In many places broad highland valleys, with cultivated fields, are seen, or pasture

delayed by a landslide. Costa Rica is a land in which earthquakes are of frequent occurrence, and our route passed through Cartago, formerly a town of 15,000 population, which was almost completely destroyed about two years ago. It has been partially rebuilt with one-story concrete houses, but there are still many vacant spots, and many others on which only rude shacks are located. Andrew Carnegie's palace for the Central American Court was situated in this town, and was also destroyed. I understand it will be rebuilt at San José. A statue of a former President was turned completely around, so that it faces in the opposite direction to that in which it was originally placed. Descending from Cartago 11 miles,



VISTA DEL CAMPO, COSTA RICA.

lands on which herds of cattle and other stock were contentedly grazing. The steep sides of the mountains were covered with coffee bushes, where they could get the sunshine and rain. The coffee industry is one of the chief sources of revenue of the people. They claim that Costa Rican coffee is the best in the world, but the coffee I drank was about the worst I had ever tasted. But perhaps I was not sufficiently educated to appreciate it. One disadvantage in traveling by rail in this country is the frequent landslides and washouts that occur, so that one can never tell when he goes into the interior whether he will be able to get back again in any reasonable time. We were assured that there would be no such catastrophe during our visit, as it only occurred later in the year; nevertheless, a few days later the train was

we come to San José, situated on a plateau 5000 feet above sea level. The situation is beautiful—almost like a huge amphitheater surrounded by mountain ranges. The city is attractive in appearance, with low houses of Spanish type, tinted in varying colors. The streets are rather narrow, but are fairly well paved and are kept clean. Trolley lines run in several directions, and there is considerable bustle in the streets, with carriages numerous and cheap, drawn by good horses. Occasionally one of the heavy-wheeled carts, drawn by slow-moving oxen, rumbles by. The yoke does not rest on the neck, as with us, but is attached to the horns, and the driver guides his team with a goad, with which he strikes them. Buzzards sit upon the roofs of the houses and wander about the streets, and doubtless they are important mem-

bers of the street-cleaning department. These birds are black, but have lead-colored heads, and differ in appearance from the turkey buzzard of the temperate zone. We secured rooms at the Imperial Hotel, which is imperial only in name. The accommodations were crude and the fare poor. Early breakfast, from 6 to 7.30, consisted of poor coffee, rolls with bad butter and two eggs. Late breakfast, 12 to 1, was really a lunch of soup, one meat, vegetables and dessert, and dinner, 6 to 7, was about the same as lunch. None of the food was good, but some was not as bad as the rest. One of the great needs of all these Central American cities is decent hotels. Even in Guatemala City the hotel accommodations are very in-

and other objects, made by the ancient Indians and exhumed from their graves. The Presidential Palace is an unpretentious building, one story in height, with two handsome reception-rooms, furnished in red and gilt. I only suspected it to be the Presidential residence from the fact that a sentry was on guard in front of the building. There is but little militarism in Costa Rica, the standing army consisting of only 500 men. They say they have no need of an army, as Uncle Sam will not let them fight, and, besides, they are too busy to engage in warfare.

The Hall of Congress is situated across the street from the Imperial Hotel, and is a very nice and well-furnished room. We were courteously



ARBOL DE LA PAZ. PEACE TREE.

different. Strange to say, the Theatro Nacional in San José is one of the most magnificent theaters in the two Americas, and there is probably no playhouse in the United States that compares with it in beauty. We heard a poor performance of Lucia di Lammermoor by an Italian juvenile company. Even if the singing was rather indifferent, at least one had the opportunity to see the fashionable life of this little republic. People here appear very much as they are in other civilized countries; the ladies were dressed in the latest fashions, and many of them were very attractive in appearance. The gentlemen were good-looking, though rather swarthy, and were in conventional dress. There is a National Museum, with a good collection of Indian pottery and implements, and some remarkable gold figures of animals, bells

received by the Speaker and members of Congress, who expressed great interest in the approaching Presidential election in the United States. There is a large and substantial cathedral, as well as several churches in the city, which have been more or less damaged by earthquakes. The Latin-American peoples are music-loving and light-hearted; they like to walk around the little parks, listening to the excellent bands and casting admiring glances at the girls. The girls are pretty, and wear their hair down the back or tied behind the neck with a ribbon matching in color the inevitable silk shawl that is worn around the shoulders. A girl may go barefooted, but she wears a silk shawl over her shabby dress. We were fortunate in being invited to visit the home of a prominent gentleman and lady on the out-

skirts of the city, and to obtain some idea of the home life of the better class of the people. This home is a typical Spanish house, of only one story, surrounding an open court or patio, in which were flowers and shrubbery and a rare collection of tropical birds, while in the surrounding grounds were almost all kinds of tropical fruits and vegetables. The question is often asked, Is the climate very hot? In the central elevated portions of Central America the climate is cool and bracing, but on the coast it is hot and debilitating. At San José light wraps and overcoats were very comfortable after dark. Daylight ends suddenly and night sets in. There is no twilight, as in more northern countries. A very noticeable character-

sailed for Colon on the return voyage. At Limon we took on 50 huge sea turtles destined to Europe. Two of them died before reaching Colon. They are placed on their backs and are unable to turn over. We also took on a motley deck load of Jamaican negroes—men, women and children—who lived, ate and slept on the open deck for three days and nights. Many of them were seasick, and they must have suffered intensely, but they got off at Kingston as lively as rabbits. We only stopped a few hours at Colon, and then put out across the Caribbean Sea to Kingston. We stayed here 24 hours, taking on a cargo of bananas, and as it was a holiday to celebrate the emancipation of the slaves, the stores were closed



CALLE DEL PADRE PICO—PADRE PICO STREET.

istic of the people is their uniform politeness—from the Speaker of Congress to the policemen we were treated with marked courtesy. A visit to the market was interesting, though perhaps not very appetizing. San José is situated nearly midway between the two seas, and has an inter-oceanic railroad connection. The Pacific slope is more populous and more prosperous than the Atlantic side of the country. Coffee is the standard product on the west, as bananas are on the east. Doubtless the country is largely undeveloped, and will become a more important center as American capital and industry is attracted to a larger degree.

From San José I retraced my steps towards the coast, arriving without mishap at Port Limon, where, after an uninteresting stay of 24 hours, we

and there was nothing to do. Early the next morning we were approaching the Cuban coast, and soon thereafter the grim walls of Morro Castle came into view. The entrance to the harbor of Santiago de Cuba is very narrow, only a few hundred feet wide, and two ships cannot pass abreast. Morro Castle is an ancient fortification situated on a bluff overlooking the entrance and absolutely dominating it. It is now practically dismantled, and is not formidable as a defense. From the sea the city is not visible, and it is only after traversing a narrow and crooked channel that ships enter a considerable-sized bay, and the town is seen situated at its upper end. As the narrow entrance is easily defended by means of earthworks and torpedoes, we can readily understand why Sampson did not risk his ships in an

attempt to force the passage; and if Hobson had succeeded in sinking the Merrimac across the channel instead of on the edge of it, the Spanish ships would have been bottled up. The harbor, with its islands and heavily-wooded hillsides, is very picturesque, and the city, with its varicolored buildings, is like a signet in a ring. The bay is rather shallow, and ships must anchor at some distance from the shore, though some of the smaller ones dock at the wharves. Drs. Brooks and Miranda kindly came out to meet us and took us ashore in Dr. Brooks' motor-boat. They then took us an auto ride through the city and as far as the Treaty Tree, where the capitulation of the city took place in 1898. San Juan Hill could be seen at a little distance, but our time was so limited we could not visit it. Santiago is an attractive-looking city of Spanish type, with low houses and narrow streets within the city, and with beautiful villas in the suburbs. The location is hilly and the houses rise in tiers, so that from many of them a beautiful view of the harbor is had. The negro insurrection had only recently

been suppressed and many troops were quartered in the city. A company of infantry marched past to embark for Havana, looking very much like United States regulars. It is said that 6000 negroes revolted, and that 5000 were killed and 1000 taken prisoners. In consequence of this insurrection several thousand United States marines were sent to the island, and as we came up the coast we passed a transport filled with them returning home. It is a great regret to me that I could not land when I was in Santiago harbor on July 18, and an equal disappointment that our captain would only allow us two hours on our second visit. My sincere thanks are extended to the University of Maryland men who did their best to entertain us on both occasions. About 40 miles from Santiago is Guantanamo Bay, a large sheet of deep water, which is a United States naval station. Passing Cape Maysi, we left the Caribbean Sea, and after four days of pleasant sailing on the Atlantic Ocean we sighted land near Barnegat Light, and passing along the electrically-illuminated New Jersey coast, dropped our anchor in New York Bay on August 6 at 11 P. M.

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## THE AIMS OF CLINICAL TEACHING IN MEDICINE.

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Our academic pageant must certainly leave a vivid impression upon the spectators and must show to the world the realization of the principles "crescat, floreat, et fructat" of our Alma Mater. To the members of our communion, however, Academic Day has a far different meaning; it is the visible sign of our strength and union in the interests and in the progress of our institution dedicated to spread culture and scientific knowledge among our nation. The view of such a distinguished assembly alone already conveys to the mind the sensation of happiness in belonging to the medical faculty of such a renowned University.

If on this occasion we miss the late Provost, Bernard Carter, and John Wirt Randall, both members of the Board of Regents, whose activities in the interests of our Alma Mater we cannot but appreciate, still we feel ourselves united with the spirit of the departed and with the memory of all the men who have contributed to the glory of our

school. With reference to their aims, with reference to our present duties, we recognize the obligation to contribute our best to the progressive evolution of the University of Maryland. Viewing this assembly one realizes the great responsibility of preparing the student for his practical and professional duties and assuring him the greatest benefit from his studies. The teacher must start with a clear conception of the course to follow, and must be familiar with the means at his disposal in order to make his task successful.

In a country like the United States, where everything is in full development and the work accomplished in the different universities proves the continuous growth towards perfection, the task of the professor of the practice of medicine becomes very important and attractive. The American medical institutions, encouraged by the financial support of broadminded donors, are trying to give their students the very best instruction and to offer them splendid material for their

clinical and practical training. The methods of medical instruction in these institutions is based on the heritage of scientific knowledge of previous centuries, and shows a wonderful improvement, arousing the interest and admiration of the universities in the old country. Just as the splendid invention of Marconi has overcome space, so human intelligence makes the whole world akin, so medical science finds its way everywhere. American medical science and research is recognized as a very important factor in the untiring fight against disease, and its accomplishments exert an attractive influence on the graduates of European universities. In increasing numbers foreign doctors wishing to complete their studies come to American universities, and when they return to their mother country they take pleasure in reporting to their colleagues the creditable work they have witnessed on their way from east to west through the continent of unlimited possibilities. Broadminded men, taking so much interest in the successful growth of the American universities, however, are always busy finding new means for better instruction. Comparison with the methods of foreign centers of learning leads them to adopt new ideas for harmonious cooperation among their teachers and so to increase the practical benefits of a thorough and systematic training of the students. It is remarkable to watch this work, accomplished in such a short time, and American universities can be proud of their showing in competition with foreign institutions. So the medical profession by its knowledge, its thorough experience, will add to the glory of the American nation. Among the prominent facts of American medical accomplishments I can mention only a few: the world-wide reputation of the Rockefeller institution for medical research, whose investigations have contributed so much to our present knowledge; the energy shown in the fight against the white plague; the work of sanitation pursued in transforming pest and plague-ridden cities into the most healthful and delightful cities of the world, Havana, for instance; an accomplishment we owe to the ingenious work of Gen. Leonard Wood. At the present time we notice with satisfaction a well organized army of philanthropists and eminent scientific men arrayed in the bloodless battle against human suffering and disease instead of the old-time bloody conquest of territories. These disciples and pro-

moters of science do not only devote all their time, all their energy, their genius to difficult research work, but their enthusiasm in science and in the progress of new methods in preventing and healing diseases leads them to pay with their lives for their beautiful discoveries. The martyrdom and heroism of Dr. James Carroll, our alumnus, who offered himself to be infected with the deadly agent of yellow fever, and who died from the remote effects of this dreadful disease a few years after voluntary submission to infection, is an unique accomplishment in the annals of the history of medicine. If we consider that the other two members of the Yellow Fever Commission, Major Walter Reed, U. S. A.; Dr. Jesse W. Lazear, also died as the victims of these dangerous investigations, and that owing to their discoveries the proper ways of prophylaxis of yellow fever have been found, we must admire such heroism. Such examples kindle our enthusiasm in scientific work, and following their steps we should be able to contribute to humanity by our own work. It is no doubt a great privilege for the University of Maryland to claim Dr. James Carroll, the immortal martyr of science, as one of her alumni. Dr. James Carroll's teachers of the University of Maryland had their share in kindling in their pupil this admirable devotion, enthusiasm and love for science. The history of the University of Maryland, the accomplishments of our Alma Mater, in relatively short time, is a splendid proof of the high ideals of this institution. The great distinction the university enjoys among other American and foreign universities is the result of the work accomplished by its famous teachers and alumni. As different members of the same body, gifted with different talents, by faithful, untiring perseverance in their work, by their personality, their genius, by a noble demonstration of the ideals of life, they all have contributed to their best ability to the glory of the university, and it is such a difficult task to render full justice to all the prominent medical men who, by their contributions, have added to the fame of the university, and through them have won the recognition of other institutions here and abroad.

A review of the accomplishments of the University of Maryland in the past fills us with admiration of the work done by teachers connected with this school. The names of Dr. George Brown, Dr. Nathaniel Potter, Dr. Elisha Bartlett, Dr. William Power, Dr. Samuel Chew, Prof.



Richard McSherry, Prof. Samuel S. Chew, Prof. C. W. Mitchell recall to the memory of the auditors the qualities of these excellent men, to whom we feel greatly indebted. The scientific work originated in the laboratories and clinics of the university proves that the men in charge of the medical instruction are working hard for the spread of science and experience. They have acquired not only distinction in this country, also they are well known among foreign scientific writers and investigators.

Among the number of clinical and scientific results, only a few may be mentioned which have greatly contributed to the renown of our Alma Mater. Owing to the untiring work of all the members of the surgical department its fame in successful operations has spread almost over the entire country. Valuable scientific information can be ascribed to different papers written by the members of our faculty. So our knowledge has greatly improved with regard to the surgery of infants, of the thyroid gland, the pathology of the hyoid bone, the surgery of the gall-bladder, tuberculosis of the kidneys, tubercular peritonitis, Meckel's diverticulum, etc. The four large volumes on the diseases of the stomach form the first complete work on diseases of the stomach published in the English language, and are highly accredited by the most renowned clinical teachers as a standard work for the whole medical world. Not less renowned are the two volumes of diseases of the intestines and the manual of Physiology by the same writer; they all furnish a splendid proof of the competency of the teachers at this university.

The medical profession is also indebted to teachers of the University of Maryland for various scientific discoveries. The X-ray, until recently employed only in the demonstration of diseases of the bones, was first used in the recognition of diseases of the digestive tract by teachers in the University of Maryland. The Heterochylia, later confirmed by Ewald and Boas in Berlin and now an established fact in medical science, was discovered in the laboratory of the University of Maryland.

Also the intubation of the duodenum, published in 1897, is due to the same skillful and untiring investigator of our school. The causal connection existing between the salivary glands and the stomach secretion, showing that the extirpation of the first mentioned organs results in a loss of

secretion of the gastric glands, is another result of the scientific work carried out in the University's laboratories. These results, though attacked by investigators who were not familiar with the technic, were confirmed in Bickel's laboratory in Berlin. Recent discoveries in the physiology of the heart demonstrating that no chemical substance is produced in the myocardium, that was arrested by stimulation of the vagus, so that the inhibition of the heart calls forth another explanation. To accomplish this latter discovery the faculty of medicine allowed several wagon-loads of valuable instruments of precision kymographs, etc., to be transported to the laboratory of the United States Fish Commission at Woods Hole, Mass., where the scientific investigators, Professor Hemmeter and Dr. Albert H. Carroll, were working. This liberality on the part of the Medical Faculty in encouraging scientific research work deserves especial praise. Scientific investigation in metabolism carried out in the laboratory of our hospital demonstrates the capital importance of a careful study of quantitative dietetics. The careful analysis of the blood serum, the defective or insufficient elimination of noxious substances through the kidneys represent an enormous amount of work, which by its practical application in the change of diet secured the suffering patients remarkable improvement or recovery from their ailments, which until then had baffled the skill of other physicians. Careful study of gastro-intestinal cases by recent means of investigation allow an accurate localization and diagnosis of the pathological process, which conditions stood the proof of the autopsy in vivo, by the surgical members of our faculty are certainly accomplishments which corroborate the impression that the members of the University of Maryland stand in the foremost rank of American medical authors. The "History of Medicine" has received valuable contributions from one of the members of our faculty. Not only the remote Augustean ideas on medicine and the Greek era have become more accessible to our understanding, but also the life and accomplishments of famous members of the medical profession—such men as Charles Frederick Wiesenthal, Henry Keerl, Gustavus Brown—all the facts in regard to the lives of past and present members of our University have been carefully collected in the "History of the University of Maryland," so that



future generations will derive therefrom valuable historical information.

These allusions will demonstrate that the University of Maryland stands in the foremost rank of scientific work and any one associated with the interests of this scientific body must experience a satisfaction and pleasure in joining these ranks of progressive workers and wish to help as much as possible in the realization of plans destined to increase the fame of our Alma Mater. Elected to the chair of practice of medicine, I wish to thank the Board of Regents and the members of the Faculty of Physic of the University of Maryland for this high distinction. In accepting such a position, I feel the great responsibility of my work and am impressed with the accomplishments of my predecessors. It is therefore my sincere wish to maintain the high standard of medical teaching at the University of Maryland. I hope that my previous medical training with prominent medical professors of this and of the old country, their ideals of progressive teaching will help me to justify the confidence of the Faculty of Physic. I hope that mutual understanding with the members of the faculty will favor a successful work for the best of our institution, so contributing steadily to a still greater future for our Alma Mater.

Medical instruction nowadays has become such a complex question that the task of best benefiting the student appears very difficult. Influenced by many different factors, by local conditions, the results vary accordingly. First of all, the aims in teaching the students the essentials for their future profession are to be considered; next, the resources of the institution, and finally, the standard of the students; their psychic and ethical qualities forming a great factor in successful teaching.

In regard to the splendid results in surgery, the question arises whether more weight should be laid on a careful instruction in this sister branch of internal medicine. No doubt the conquests of the knife in the hands of a skillful surgeon and the wonderful results in the warfare against disease and death inspire admiration; whereas, in internal medicine the results of treatment appear only slowly and after much painstaking labor. The student may feel inclined to devote himself more to surgery than to internal medicine. At the conclusion of their studies a greater number of them tend their efforts to be-

come famous surgeons and only a small percentage of promising pupils remain faithful adherents to internal medicine. Since, with the security of careful asepsis the autopsy *in vivo* very often discloses without much trouble the real cause of disease, is it still necessary for the student to undergo thorough training in the methods of physical diagnosis? Is it justifiable to subject the patient to laborious, time-robbing methods of investigation? Is it necessary to resort to the use of expensive apparatus for the sake of a more definite diagnosis, where the knife and the experienced eye can easily control the morbid process in regard to its extent and its localization? In my opinion, the student's training in internal medicine is of primary importance, since we have not yet reached the time where the public itself willingly and freely submits to the more extensive benefit of the surgeon's knife. We all agree that a specialty considered only for itself, severed from its relationship to other disciplines, separated from the broad foundation of general medicine, is likely to lead to errors. More and more we have to demand that the specialist undergoes a thorough training in the principal branches of general medicine, as a reliable basis upon which to build his specialty. For the good surgeon, it is of the greatest importance that his connection with the principles of internal medicine are never severed. Notwithstanding the excellent preparatory instruction given to the student, as soon as he enters upon the practical clinical studies it seems that he has first to be taught to use his senses. His power for close observation of the patient has to be developed, as the outward observation of the patient in many instances can furnish important information in the case. The ear requires the subtle training of the musician to differentiate the quality, the tonality of the sounds transmitted to the surface of the body. The delicate touch of the fingers has to be trained to differentiate the outlines, the resistancy, the qualities of vibration of the underlying organs. The acuity of smell has to be educated in order that pathological changes imparted to the air may not be overlooked. These requirements are important factors in medical diagnosis and they are obtained only by an assiduous, thorough training in the methods of physical diagnosis. Next to these simple means of diagnosis, human genius has furnished us with much expensive apparatus as valuable helps to a more accurate un-

derstanding of the pathological processes. The young student may think his diagnosis incomplete without resorting to these elaborate means of investigation. In professional practice, however, the public unfortunately not always consents to such tedious methods of clinical diagnosis. Often the patients lack understanding of the advantages of such methods; often their financial resources are restricted and forbid such expense. In some instances we remark the great difference in results between surgery and internal medicine.

Modern surgery, as an exact science, has advanced by leaps and bounds owing to the immense opportunities of proving in every case the correctness or incorrectness of diagnosis by the autopsy in vivo in internal medicine. In a few diseases only—typhoid fever, diphtheria, tuberculosis, relapsing fever, malaria—the control of diagnosis is obtained by the laboratory methods: for instance, by examination of the blood. And still so many changes and complications within the internal organs escape our attention because of the impossibility of post-mortem examination. It must be our aim to destroy the opinion that medical diagnosis in this country often is regarded as a matter of clever guessing without the necessary demonstration whether one is right or wrong. The value of post-mortem examinations, where every mistake made in diagnosis is revealed, can never be overestimated. There is some truth in the assertion that students will learn only by the mistakes of their professors, and later by their own in the position of hospital physicians. Unless they are taught by their own mistakes, they will never become good diagnosticians. Unless they have acquired this quality of taking advantage of exceptional opportunities during their years of study in the hospitals their patients will be inadequately cared for. The percentage of post-mortems among patients who die in our hospitals is absurdly small as compared with that in other civilized countries. Few hospitals are able to hold post-mortem examinations on 10 per cent. to 25 per cent. or even less of their dead. In foreign hospitals, well over 75 per cent. is the rule; in Vienna practically 100 per cent. Even in the old Montreal General Hospital of the splendid Royal Victoria Hospital, the hospital reserves the right to perform an autopsy upon every patient dying within its walls. Nothing could more advance medical science and

nothing could more increase the efficiency of every-day practice than the education of the vast mass of the population, so that they may appreciate the fundamental necessity of autopsies if they are to have physicians of any value to them when their time comes to be ill. It should be the aim of medical education that the well trained physician wherever he is called, even to the remotest corners far distant from the centers of civilization, should be trained so that his close observation, his well-trained eyes, ears and fingers render him valuable service. These qualities direct him to the right diagnosis, even under unfavorable extrinsic circumstances. Supposing that later on a surgeon and pathologist are called to control the physician's findings, is it not gratifying if his diagnosis is confirmed by these professional friends? Does it not mean a great blessing to the patient if his case, in the eyes of his physician, becomes transparent, when close observation, accurate examination, personal experience and thorough knowledge of pathology and symptomatology contribute not only to diagnosis, but prognosticate the chances for recovery? At all times the diagnostic skill of clinical teachers has attracted hundreds of students and post-graduates, and their lessons were followed with eager interest. It cannot be denied that these masters, too, are handicapped by external conditions, that in some instances they were mistaken; but this meant only a stimulant to them in aiming at higher perfection of their methods.

If we admit the primary importance of clinical training of the medical student, the practical solution of this problem will never be absolutely objective. Every teacher, enthusiastic of his own methods, imparts to his teaching his personal character. As a rule medical instruction follows the laws of evolution. It means a gradual rise from simple tasks to more complex problems, until the pupil reaches a position from where we see him safely and independently advance on the way to perfection. The course of evolution from the medical student to the accomplished medical man reminds me of the construction of a skyscraper; these long-lasting monuments of human skill and genius in modern technic. From the solid foundation, amalgamated with mother earth, we see the big steel frame point toward the sky, gradually the gaping spaces are filled out and finally we see the work completed as a beautiful monument, able to face all elements; all

extrinsic influences of its surroundings. The foundations of the students' knowledge are the natural sciences, anatomy and physiology, upon which all the subsequent instruction is built. If the greatest care has not been taken to make this basis as strong as possible, if there are unfilled gaps left, the energy of the student is generally not strong enough to reinforce these weak points of his knowledge by personal studies. The work of previous teachers deserves our appreciation, and training in the principles of clinical medicine forms only a necessary and important link in the chain of influences to which the student must be exposed. Our main object must always be to give the student practical as well as theoretical knowledge: so that when he has to show the extent of his knowledge before the State board and before the public, he will be able to qualify as a most useful member of the medical profession.

Theoretical knowledge has to precede practical instruction; therefore, the student had better master didactic medicine in his third year. Besides his training in physical diagnosis, he must study the dispensary, for this prepares him for a greater and more successful understanding of the medical clinic. At the dispensary, under the supervision of the professor, the student acquires his experience in history taking, in the practice of physical diagnosis, in judging the cases with regard to prognosis and treatment. There, in daily contact with the suffering of poorer patients, the student sees that medicine means a much larger field of activity than is generally admitted. Not disease itself only, but diseased individuals have to be cared for; often the social surroundings have to be improved before any evident success is to be hoped for. This is the opportunity at which the student shows the qualities of his character and where he can excel in following the demands of charity. At first the student follows the medical clinic as an auditor, listening to the clinical exposition of the cases presented and taking advantage of the answers of the senior students, who are called to examine and debate on the clinical cases. Unfortunately the medical classes are always large, and therefore the difficulty which arises is how to find space large enough to teach juniors and seniors together. No doubt the system of co-education of juniors and seniors offers many advantages. The junior student, eager to progress in the understanding of clinical medicine, has an oppor-

tunity to show his teacher that he can ably answer the questions calculated for the senior. For the senior this co-education is a powerful stimulant to a more thorough knowledge. He generally dislikes to expose his ignorance to the criticism of his junior fellow-students. So first-class work becomes second nature to the senior student. He experiences the advantages to himself, and the good habit is formed. The principal aim in the instruction of the senior student is his practical clinical training. In the clinic, at the bedside of the patient, the framework of his knowledge is filled out by important details in the symptomatology, pathology, diagnosis and treatment of each case. He is entrusted to work out his clinical cases carefully, to make most of the examinations himself, to discuss thoroughly before the whole audience his findings. Allowed to follow his patient more closely in the ward, the student is fortunate to gather important information on the course of the case, reporting upon it to his teacher. A short review of the case may be helpful and leave a deeper, longer-lasting impression in his memory. Conferences on clinical fatal cases conjointly with the professor of pathology may be another help for clinical instruction. So step by step the clinical teacher will see his pupil grow into a medical personality to whom he can entrust any case, convinced that the pupil will do his best work. This is the aim of clinical teaching and the sincere wish of the teacher is to conduct all his pupils to careful training, to reliable practical experience and perfect knowledge.

With the teaching of the students, the task of the clinical professor is far from being completed. His influence has to extend to his assistants, who conscientiously do the work in the different wards. In making rounds in the wards there is so much opportunity to control and advance the work of the young colleague; to help him to reach the goal of an accomplished physician and teacher. His interest in medical problems, in useful ingenious research work, can be aroused and trained. The medical clinic, an institution destined to promote medical science and control by close observation on a greater scale the assertions and suggestions of outside investigators, must aim to give its alumni and the members of the medical profession reliable information about the value of new methods of diagnosis and treatment. But also to outside physicians

and to alumni the medical clinic has to be the seat of learning wherefrom valuable information can always be obtained; it has to favor genuine research work, accomplished by its own means. The practitioner, conscious of some lack of experience in certain branches of clinical medicine, should always find there an opportunity for post-graduate work. Cases doubtful in regard to diagnosis should be referred to the medical clinic for further careful observation and examination. A similar suggestion might be made for insurance and medico legal cases, where greater opportunities are available for a better interpretation of the pathognostic features. Without doubt, there are many factors that make the task of the professor for the practice of medicine very attractive, and which can only be briefly mentioned. The resources of our institutions are well known and much appreciated. In this work, gradually expanding, it is to be hoped that more influential and benevolent men may become interested in the present and future tasks of the University of Maryland, and from their abundant financial means will contribute to the success of our ideals in medical teaching. The standard of students, the psychical qualities of the medical man, is a vast and important topic which may be better exposed before the students themselves.

Finally, I would mention one point of interest to the medical profession. It is the conviction of the leading classes that medical art in this country is still in its infancy and that with all our distinguished medical men difficult medical cases cannot be treated properly at home. As a proof of the proverb, "A prophet is not without honor, except in his own country." Every year we notice quite an exodus of wealthy patients making their way to the clinics of Europe. It is an open question whether they will receive better attention over there than they would have at home, but this means a serious danger to the fame of the American profession. At this instance an experience of a Baltimorean may be quoted, who visited Professor Strümpell at Breslau. The professor asked the patient where he was from. The answer from the patient, "From Baltimore, sir." Professor Strümpell said: "Then go back and put yourself under the care of one of our distinguished members of the faculty of the University of Maryland." So it will be the duty of the universities to join the ranks of benefactors to humanity to show the public that the medical

profession gets an instruction in all branches of medicine, comprising physical treatment, balneo-climato-dietotherapy; that reliable institutions are directed by well experienced doctors just as in the old country, and that the results compare favorably with those reported from abroad. No doubt this aim will be reached in time and fostered by the financial help of the public, this onward movement to perfection in all branches of medical experience and teaching will add another laurel to the reputation of the American nation.

In conclusion of my discussion of the aims of clinical teaching of medicine, I only hope that the work at the medical clinic has but begun *viribus unitis* of the past and the present. In such a task the interest of the University of Maryland and its medical faculty is not only at stake, but also the interests of the entire medical profession. In the proper education of the medical students, we have to contribute our share to humanity as well as to the benefit of our country, whom we try to serve with our best.

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#### A PROBABLE CASE OF INFANTILE PARALYSIS IN ANCIENT EGYPT.

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By EJNAR HANSEN.

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Dr. Hamburger of Copenhagen, who, besides his duties as a physician, devotes part of his time to the study of the art of ancient Egypt, speaks of human abnormalities often met with; some easily recognized by everyone, but also others misunderstood by the Egyptologist on account of lack of anatomical and pathological knowledge. Many of these last named are often explained as being a mistake of the artist.

The following is from an article in *Ugeskrift for Læger* by Dr. Hamburger:

"In the Egyptian division of 'Ny Carlsberg Glyptothek,' Copenhagen, you will find a 'Stele' (monumental stone plate) dating from the eighteenth dynasty, about 2500 years before Christ.

"On this plate can be seen three human figures surrounded by hieroglyphics. The principal figure is a man with a bowl in his left hand; his head is shaven, which indicates he is a priest. Around his hips is a cloth, reaching to his knees, but made of such transparent material that both his thighs are easily seen. Behind him you see a woman, his wife. In her left hand she is carry-



Engraving from a Library in Copenhagen, which illustrates the possibility that the ancient Egyptians suffered with infantile paralysis.

ing a sacrificial bowl; the right hand is leading a sacrificial lamb. In the farthest right corner you see the figure of a little child.

"The hieroglyphics tells us the man's name is 'Ruma,' and that he is the caretaker of the temple.

"The goddess to whom he is making an offering is the Syrian 'Astarte,' who, according to Herodotus, had a temple in Memphis, in lower Egypt. The names of the man and woman are Syrian; the boy's name Egyptian.

"When you look closely you will see that the figures are cut very distinctly by the artist, with precision and delicacy, but also that there is something wrong with the man's leg.

"Of course, this abnormality has been noticed, and in the catalogue you read: *The drawing is not especially good. The man's one foot and leg is absolutely deformed; the 'Stele' is possibly from a later period, when the Egyptian art was decadent.* If the aforequoted Egyptologist had been a physician, he would surely not have made that statement.

"In this case there is undoubtedly no misdrawing. The artist has produced a man with a

'withered' leg. The foot is in the typical *Equinus-position*. The slight flexion of the hip and knee joints is not enough to raise the heel so high from the ground. There is a shortening of femur, tibia and fibula. The whole leg is diminished in size. Another thing that speaks for the correctness of the drawing is the way *Ruma* is carrying his staff.

"It is originally the kind of cane Egyptians of quality used to carry, but in old pictures we always see them carrying it in front of them, and parallel with the body.

"*Ruma* is carrying his cane in an unusual way, crosswise from the shoulder, in the bend of the elbow and alongside the withered leg, apparently as a support.

"If the artist has drawn the man as he was in life, it seems natural to think of either infantile paralysis or coxitis as being the cause of the deformity, and of these two infantile paralysis seems the most probable.

"The stone tells us a little tale of 3500 years ago. The Syrian *Ruma* who has had an attack of infantile paralysis does not die of it; he grows up with his withered leg and his pes equinus; he marries a Syrian woman, and they both emigrate to Egypt, where he becomes a priest in *Astartes'* temple, in Memphis. A son is born in Egypt; the hieroglyphics give us his Egyptian name.

"*Ruma* dies, and the artist draws his picture on a tombstone, carefully bringing in the withered leg and the pes equinus.

"The drawing does not tell whether poor *Ruma* ever was treated by an orthopedic specialist, but if he was, the treatment was not very successful."

221 W. 57th Street, New York.

Among the University alumni practicing in Arkansas are:

Camden—George W. Hudson, class of 1875.

Dardanelle—A. H. McKenzie, class of 1872.

Fort Smith—Errett Campbell Myers, class of 1879, Arkansas Valley Transit Building.

Hot Springs—Jos. Smith Horner, class of 1883, 430½ Central avenue; Wm. Turnor Wooten, class of 1899, Dugan-Steuart Building.

Pine Bluff—Thomas Littleton Savin, class of 1896, Barraque and Pine streets.

Texarkana—Leonce J. Kosminsky, class of 1906.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, DECEMBER 15, 1912.

## ILLNESS OF PROF. JOHN C. HEMMETER.

Professor Hemmeter has been in poor health for some time, but has been able to attend to his duties at the University and to his private practice. He arranged and was present at the Academic Day exercises, and at the luncheon at the Emerson Hotel on the same day. Two days later he was taken ill and has been under the care of Prof. Zueblin since that time. It is with great pleasure that we announce an improvement in his condition, though it may be some time before he will be able to resume his work.

Professor Hemmeter is a great ornament to the University, and his enforced absence is a great loss to us. May the good God restore him to health and usefulness!

## CLINICS AT THE UNIVERSITY HOSPITAL.

The month of November was especially signalized by the visits of many distinguished men to the University Hospital. Early in the month Dr. Arthur Dean Bevan, professor of surgery in Rush Medical College, met the representatives of the three Baltimore medical schools at a luncheon given by the hospital, and urged the necessity of a combination of these schools. We believe his efforts will bear fruit in the near future. Later the Interurban Orthopedic Club attended a clinic held by Drs. Randolph Winslow, Irving J. Spear and Compton Riely. The next day Dr. Fred H. Albee of New York demonstrated his method of grafting a piece of bone from the tibia into the vertebral column in Potts' disease. The operation

is not difficult, and the results are said to be remarkable.

The Nu Sigma Nu Fraternity held its annual convention in Baltimore during the Thanksgiving holidays and attended a clinic at the hospital, at which Drs. R. Tunstall Taylor, Jose L. Hirsh and Hiram Woods gave instructive discourses. We were also favored with two very instructive clinics for our senior class by Dr. Richard C. Cabot of Harvard Medical School. Dr. Cabot departed from the usual way of conducting clinics by adopting the quiz method. The students were taken by surprise when he called them by name and made them work out the subject. This method is by no means new to them, however, as Professor Mitchell has long taught in this manner, and the other clinical teachers to a large extent do the same. Professor Cabot's clinics were on heart disease and neurasthenia, and we were able to supply him with a good supply of illustrative cases.

## A HANDSOME GIFT.

The Academic Day exercises on November 12 were dignified and striking, though perhaps a little sombre, as two of the addresses were memorial tributes to our late Provost, Bernard Carter, LL.D., and to John Wirt Randall, LL.D., President of the Board of Governors and Visitors of St. John's College and a Regent of the University. Prof. Ernest Zueblin made an enthusiastic and inspiring address on the "Aims of Clinical Teaching." The most important feature of the occasion, however, was the announcement by the acting Provost, Judge Stockbridge, of an additional gift by Prof. and Mrs. John C. Hemmeter of \$5300 towards the endowment of the Hemmeter chair of physiology. Their gifts now amount to about \$10,000. The amount available for the department of pathology now approximates \$20,000, and is slowly increasing, though not in proportion to the effort that has been expended in the endeavor. Will not some generously disposed people aid us to raise the \$100,000 we need so sorely?

### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	81 84

1873.....	441 83
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	252 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	115 00
1899.....	55 00
1900.....	215 00
1901.....	270 00
1902.....	330 00
1903.....	340 00
1904.....	135 00
1905.....	220 00
1906.....	175 00
1907.....	110 00
1908.....	20 00
1909.....	15 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to Dec. 1, 1912..\$10,322 17

#### NEW SUBSCRIPTIONS IN NOVEMBER.

Horace M. Simmons, 1881.....	\$2 00
J. Royston Green, 1899.....	5 00
Daniel A. Watkins, 1903.....	25 00
John S. Norman, 1909.....	10 00

Total ..... \$42 00

Mr. Albert O. McFaddin of the junior medical class, who has been for several months confined to the hospital suffering from typhoid fever, has fully recovered and is now attending his class lectures.

## ITEMS

A committee of one member from each department of the University was appointed in September to consider the selection of a provost to succeed the late Bernard Carter. The members of the committee are Philemon H. Tuck of the Department of Arts and Science, Dr. Thomas A. Ashby of the Department of Medicine, Joseph C. France of the Department of Law, Dr. Timothy O. Heatwole of the Department of Dentistry and Dr. David M. R. Culbreth of the Department of Pharmacy. The committee will recommend to the Board of Regents at its meeting this month that Dr. Thomas Fell, for 26 years president of St. John's College, be named as Mr. Carter's successor. The plan as proposed, according to current rumor, is that Dr. Fell will be asked to open an office at the University and give Saturdays and at least two afternoons a week to the work of the entire institution. An office force will be selected to assist him. The *Sun*, in speaking of Dr. Fell, says:

"Dr Fell is regarded as one of the leading educators of this part of the country. His ability as an administrator has been tried as the president of St. John's College. In the opinion of all who have watched the growth of that institution under his leadership he has been remarkably successful.

"When he assumed charge of the old institution, which was founded in 1696 and thus ranks as one of the oldest colleges in America, a great deal of its prestige had been lost, and there was danger that it would suffer the same fate as a number of other small colleges had.

"With signal ability Dr. Fell set to work to restore St. John's to its former position. When he took charge there was a long-standing mortgage of \$30,000 hanging over the school. Through his efforts that has been entirely wiped out. The final accomplishment of his administration was the merging of St. John's with the University of Maryland."

Dr. Fell was born in Liverpool, England, July 15, 1851. His father was a surgeon in the English Army, and was killed in the Crimean War. Dr. Fell was educated at the Royal Institution School of Liverpool and at King's College, London. He later entered the University of London, and then studied for a year at the University of Munich. He came to America in 1882, and in



1884 was elected professor of ancient languages at New Windsor College, New Windsor, Md. In 1886 he was elected to the presidency of St. John's College, being the 12th president of its now 123 years of existence. St. John's College has conferred upon him the honorary degree of doctor of philosophy, and the University of the South that of doctor of civil law, while Hampton-Sidney College has honored him with the degree of doctor of laws. His standing as an educator is recognized everywhere. Dr. Fell is a member of the American Philological Association, the National Educational Association, the Phi Sigma Kappa Fraternity, the University Club of Baltimore and the Cliosophic Society of Princeton University.

Among the University alumni practicing in Colorado are:

Boulder—Wm. J. Baird, class of 1881.

Canon City—Wm. Booth, class of 1865.

Denver—William C. Mitchell, class of 1889, California Building; Edmund C. Rivers, class of 1879, 1632 Welton street; William A. Sedwick, class of 1893, Metropolitan Building.

Fort Logan—J. R. Shook, class of 1899, Major M. C., U. S. A.

Grand Junction—Samuel J. King, class of 1903.

Somerset—Morris Ramsey Bowie, class of 1908.

Dr. Louis McLane Tiffany, class of 1868, who was operated upon recently by Drs. Frank Martin and George Walker at the Union Protestant Infirmary, is reported to be considerably improved.

Dr. William F. Wegge, class of 1886, of Caswell Block, Milwaukee, Wis., was a member of the commission of five appointed to report upon the sanity of John Schrank, assailant of Col. Theodore Roosevelt. Copies of the ruling of the commission in declaring Schrank a paranoiac have been requested by large libraries throughout the country, and will be supplied to them.

Dr. John Turner, Jr., class of 1892, has just returned from a trip covering several thousand miles by way of Colon, Panama, San Francisco, Salt Lake City, Denver, Omaha, Chicago and Pittsburgh. Shortly after his return he was the victim of a telephone hoax, some anonymous

person telephoning the coroner of the Northern District that Dr. Turner had died. Dr. Turner is in the best of health, and responded in person to the many inquiries concerning his supposed death.

Dr. Henry Waters Kennard, class of 1889, has been appointed assistant superintendent of the School for Feeble-Minded at Owings Mills. He will shortly resign his commission in the State Militia as lieutenant of Company A, Medical Corps. He has been actively engaged in the National Guard for a number of years, participating in the recent encampment and in work at the armory.

Dr. John I. Pennington, class of 1869, is seriously ill at the Mercy Hospital, suffering from the effects of a fall from a street car. Dr. Pennington boarded the car and, finding it was going south instead of north, leaped off, missed his footing and fell on his head. The accident occurred near St. Paul and 23d streets. Dr. Pennington was placed aboard the car and hurried to the office of Dr. A. C. Harrison, 31 E. North avenue. Dr. Harrison examined him and took him at once to the Mercy Hospital, where he is reported to be improving.

The American Surgical Association has appointed a committee consisting of Drs. William L. Estes, South Bethlehem, Pa.; Thomas W. Huntington, San Francisco, Cal.; John B. Walker, New York City; Edward Martin, Philadelphia, and John B. Roberts, chairman, 313 S. 17th street, Philadelphia, to report on the operative and non-operative treatment of closed and open fractures of the long bones and the value of radiography in the study of these injuries. Surgeons who have published papers relating to this subject within the last 10 years will confer a favor by sending two reprints to the chairman of the committee. If no reprints are available, the titles and places of their publication are desired.

JOHN B. ROBERTS,  
Chairman.

313 S. 17th Street, Philadelphia, Pa.

We are aware that several alumni of the University have published papers on the open method of treatment, and we hope that some of them will respond to this call.



Bishop Luther Barton Wilson, a member of the medical class of 1877 and son of Dr. Henry M. Wilson, class of 1850, now resident head of the Methodist Episcopal Church of New York, celebrated his 56th birthday November 14, 1912.

A meeting of the Interurban Orthopedic Club was held on November 18 and 19, in Baltimore, with headquarters at the Belvedere Hotel. On Monday the members attended a clinic in the amphitheater of Johns Hopkins Hospital, where from 9 to 12.45 they witnessed and heard of work done by physicians connected with that institution. Dr. Henry M. Thomas, class of 1885, presented a case of periodic paralysis with muscular dystrophy. The club was then entertained at luncheon at the home of Dr. Howard A. Kelly, later going to the Children's Hospital School, on Green Spring avenue. Among the cases presented were two of fracture-dislocation of spine, by Dr. Howard Elmer Ashbury, class of 1903. The club then attended a business meeting at the Baltimore Country Club, dining there. On November 19 the first clinic was held at the Union Protestant Infirmary, and at 11 A. M. the visitors repaired to the University Hospital, where they observed the following program:

11.00—Dr. Randolph Winslow, class of 1873.—“Fracture of Neck, of Femur and of Surgical Neck of Humerus. Operative Treatment.”

11.15—Dr. Compton Riely, class of 1897.—“Remarks on Spinal Abscess. Exhibition of Radiograms and Presentation of Cases.”

11.45—Dr. Irving J. Spear, class of 1900.—“Results After Section of Posterior Spinal Nerve Roots. Exhibition of Cases.”

At 12.15 a clinic began at the Mercy Hospital. Dr. A. C. Harrison, class of 1887, demonstrated the use of the Downey extension apparatus in treatment of fracture of the femur. The afternoon was spent in inspecting the Kernan Hospital and Industrial School for Crippled Children, after being entertained there at a luncheon given by Dr. R. Tunstall Taylor, clinical professor of orthopedic surgery at the University.

Several “University-ites” are much amused because of a visit recently paid us by an alumnus of about two years ago. We understood that he had been piloted across the Styx, and had written “dead” in big letters across the card in our list which bore his name. One day recently he

walked in and disputed the question with us—said he was perfectly sure he hadn't died lately, and then—Oh, cruel!—he told the tale. And though the world says medical men are solemn, we have proof that they can laugh right heartily.

Dr. Murray P. Whichard, class of 1910, has sent us the following interesting letter in response to a query of ours concerning a rumor that he had moved to Porto Rico. We think it of sufficient interest to his fellow-classmates to reproduce it here. Dr. Whichard writes:

*“Dear Dr. Winslow:*

“Your letter of inquiry received a few days ago, and will endeavor to answer you as best I can. After taking the North Carolina Board in 1910 I came to the extreme western section of the State and began a rough country practice, but soon landed a contract practice with a big lumber concern, which paid me a salary of \$150 per month, and was also allowed to do a general practice in connection; but this concern was of a short life and discontinued business after I had been with them five months. I was sorry for this, but I know I have gotten some valuable experience, which I could not have gotten any other place.

“I am located in a small mountain town of about 200 inhabitants, and there is not a physician nearer than 20 miles in any direction, so you see I have quite a large territory to cover, and all my work has to be done on horseback, as the country is too rough to use a buggy.

“I suppose it would shock Dr. Neale's modesty to know of one of his students doing an internal podalic version without anesthetic or assistant and under conditions where asepsis is practically unknown.

“This has been my experience three times in the two years I have practiced here, and every case recovered without even so much as developing a temperature, and it would be difficult to mention the number of curettements I have done without an anesthetic.

“I also assisted Dr. R. J. Oler in an operation for peritonitis of 10 days duration with the entire abdominal cavity filled with pus, with recovery, and the interesting thing about the operation was the patient had a fecal fistula, which closed spontaneously three months after the operation.

“I notice you state you have heard I was in

Porto Rico; that is a mistake. I have been in North Carolina since I graduated.

"Respectfully yours,

"M. P. WILCHARD."

Mr. Howard Lecates of the senior class was recently operated on for appendicitis, but, we are glad to report, has entirely recovered.

Mr. E. Kilbourn Tullidge of the senior class was operated on recently in the University Hospital, deviated septum, has recovered.

Dr. Charles T. Fisher, Jr., class of 1901, of Princess Anne, Md., was a recent visitor to the University Hospital.

Mrs. Ethel Palmer Clark, superintendent of nurses in the University Hospital and a member of the Training School for Nurses, class of 1906, has just returned from a flying trip to Jacksonville, where she was called on business.

A daughter was born recently to Dr. and Mrs. A. Aldridge Matthews of Spokane, Wash. Dr. Matthews was a member of the class of 1900.

A daughter was born recently unto Dr. and Mrs. Eugene F. Raphael of Fairmont, W. Va. Dr. Raphael was a member of the class of 1905.

Prof. Randolph Winslow will attend the coming meeting of the Southern Surgical and Gynecological Association, to be held at Old Point Comfort, December 17, 18 and 19. After the conclusion of the meeting Dr. Winslow will visit his daughter, Mrs. Herbert F. Carroll, in Richmond, Virginia.

Dr. J. Mason Hundley, class of 1882, will also attend the meeting of the Southern Surgical and Gynecological Association.

Dr. Nathan Winslow, class of 1901, was elected president of the University of Maryland Medical Society at their meeting on December 10.

The basket-ball team of the University of Maryland was defeated by Georgetown University on Wednesday, December 11, by a score of 20 to 18. At the end of the regular time the score was 18 to 18, necessitating an extra period of five minutes to decide the winner.

Dr. Robert Bruce Patrick, class of 1912, is taking a special course at Johns Hopkins Hospital in diseases of the genito-urinary tract under the direction of Dr. Hugh H. Young.

Dr. Don Peters, a graduate of the University of Virginia and formerly superintendent of the Church Home and Infirmary, has been appointed an assistant in the dispensary, surgical department, of the University Hospital.

We are glad to announce that, according to latest reports, Dr. Hemmeter is progressing nicely.

## UNDERGRADUATE NOTES

*Under the Supervision of E. K. Tullidge.*

The Phi Sigma Kappa Fraternity entertained representatives from 26 universities and colleges in the United States during its biennial convention, which was held in Baltimore, November 17, 18 and 19.

The clinical assistants gave a smoker to the internes and members of the Senior faculty on the eve of November 12. Everyone thoroughly enjoyed the event, and left with a firm conviction of the generosity of their hosts.

Mr. B. Karl Blalock, after a short illness in the hospital, has recovered and is now able to resume his duties as clinical assistant.

The house men are preparing to hold their tenth annual dance for the Training School for Nurses.

The Latin-American Club is contemplating the purchase or erection of a new clubhouse near the University.

The following men have been appointed by Editor-in-Chief Earle Griffith Breeding to serve upon the staff of Terra Mariae: Frederick Leonard McDaniel, Franklin Clyde Craven, Charles Reid Edwards and W. Houston Toulson, all of the senior class. Editor Breeding requests all the members of the senior classes of the various departments to have their pictures taken

with cap and gown before December 18. He also requests that all class groups be taken and handed in to him on or before that date.

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Professor Ashby reports an excellent showing for the senior class in their re-examinations in October, but one man having failed.

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The Charles W. Mitchell Medical Society held a meeting on the evening of November 27. Hamilton J. Slusher of the senior class was elected president for the coming year.

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The reception held by the Kappa Psi Fraternity at their home, 242 East Hoffman street, on the evening of November 29 was well attended. Many of the season's debutantes were present.

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At a special meeting of the Randolph Winslow Surgical Society held on Tuesday evening, November 26, 1912, the following officers were elected for the ensuing year: President, Earle Griffith Breeding; vice-president, E. Kilbourne Tullidge; secretary, T. Ruffin Pratt; treasurer, Clarence W. Judd; historian, Robert Raymond Sellers. All are members of the senior class.

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#### NU SIGMA NU NOTES.

The seventeenth biennial convention of the Nu Sigma Nu Fraternity was held at the Hotel Belvedere, Baltimore, November 29 and 30, under the auspices of the Beta Alpha Chapter of the University of Maryland and the Beta Beta Chapter of Johns Hopkins University.

About 34 chapters of the medical schools of the United States and Canada were represented.

The entertainment consisted of a clinic given Friday afternoon by members of the fraternity at Hopkins. In the evening a model initiation was given by Beta Alpha. Saturday morning a clinic was given in orthopedic surgery at the University of Maryland by Dr. R. Tunstall Taylor. Dr. José L. Hirsh followed with an interesting talk on luetin and its aid in the diagnosis of syphilis. Dr. Hiram Woods made a short address on the "Conservation of Vision." Following this a luncheon was served at Beta Alpha House, 816 W. Lombard street.

In the evening a banquet was held at the Belvedere. Dr. Henry J. Prentis of the University of Iowa was toastmaster, and Dr. Torald Soll-

man of Western Reserve University and Dr. William Welch of Johns Hopkins made the principal addresses. Dr. John C. Hemmeter, professor of physiology and gastro-enterology in the University, of Beta Alpha Chapter, was elected to the council officers. The convention then adjourned to meet two years hence in Philadelphia, where they will be the guests of the chapters of the University of Pennsylvania and the Jefferson Medical College.

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#### MARRIAGES

John Charles Norton, M.D., class of 1912, of Hagerstown, Md., was married on December 3, 1912, to Miss Ruth Cleveland Atkinson of Baltimore. The bride is the daughter of Mr. and Mrs. William A. Atkinson of 322 N. Fulton avenue, Baltimore, and an accomplished musician.

Dr. and Mrs. Norton were fellow-students in St. Martin's Academy, where they met. Dr. Norton later took a course in pharmacy in the University of Maryland, and upon its completion entered the medical class of 1912. He is at present practicing in Hagerstown, and is assistant medical examiner of the Western Maryland Railway Company.

The ceremony was performed at St. Martin's Catholic Church by the assistant pastor, Rev. Carroll Smythe, in the presence of the immediate families and a few intimate friends. The bride was attired in a blue traveling suit, with picture hat to match, and carried a bouquet of chrysanthemums. She was given in marriage by her father. There were no attendants. A wedding breakfast was served at the residence of the bride's parents, and the couple left for a Northern tour. They will be at home after January 5 on the Washington Boulevard, Hagerstown.

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#### DEATHS

Dr. William Hand Browne, class of 1850, one of the most distinguished alumni of the University of Maryland, died at his home in Sherwood, Md., on December 12, 1912, after an illness of but one week of acute bronchitis, aged 84 years. Dr. Browne, while a graduate of the medical department, never practiced medicine, and his distinguished work was done through other channels. He was born in Baltimore in 1828, and graduated at the University of Maryland in 1850. He did

much literary work—was editor of the *Southern Review* from 1867 to 1868 and of the *Southern Magazine* from 1870 to 1875. His best work was done, however, as editor of the State Archives of Maryland. All the large libraries of England and America contain copies of this work, and the records of Maryland are perhaps more complete than those of any other of the thirteen original States.

Dr. Browne has been known for many years as one of Maryland's most scholarly and cultured men. Among his widely read and known books are his "Maryland—The History of a Palatinate;" "George and Cecilius Calvert, Barons of Baltimore," and "Life of Alexander H. Stephens." He compiled, in collaboration with Col. Richard Malcolm Johnston, the "Clarendon Dictionary of the English Language." He also translated many German and French works into English, and edited "The Trail of Rauf Coilyear," a Scottish metrical romance of the fifteenth century. At the time of his death he was professor emeritus of English literature of the Johns Hopkins University. He was librarian of the Hopkins from 1879 to 1891, being the second to fill that office. At the time he became librarian the library contained but 7000 books; at the time of his resignation it contained over 40,000 volumes. In 1880 he was appointed associate in English literature, in 1891 associate professor, and became the head of the department in 1893, resigning in June, 1910. His kindly sympathy, ready wit and great learning endeared to him his many students, and his advice was always eagerly sought.

His wife died some years ago. She was Miss Mary Catherine Owings of Baltimore. His children, all of whom were with him when he died, are Dr. Arthur Lee Browne, Mrs. Charles W. Hoff, Miss Lucy H. Browne, all of Baltimore; Prof. William Hand Browne, Jr., of the North Carolina Agricultural and Mechanical College, Raleigh, N. C., and Sidney H. Browne of New York. The pallbearers were selected from his most intimate friends and associates. They were Prof. Basil L. Gildersleeve, Dr. James W. Bright, Dr. E. C. Armstrong, Dr. E. H. Griffin, H. Oliver Thompson, Dr. Bernard C. Steiner, Clayton C. Hall, Edward Lucas White, Henry Kellogg and Dr. Cecil Dabney.

Dr. Browne was an authority, even in his student days, on matters concerning the history of Maryland and the South. He loved the country and spent as much time as possible there, and

much of his work was done in the library of his home in Ruxton. He made several trips to Europe, but was not an ardent traveler. He was very fond of music and a performer of considerable skill on the flute. Sidney Lanier, the poet, at his death, left his flute to Dr. Browne, and he loved to use it. According to the *Baltimore Sun*:

"Music, reading and walks through the country about his home constituted his recreation during the closing years of his life; in the summer of 1911 he told his friend, Professor Gildersleeve, that he had just finished reading *Livy* from cover to cover as a means of passing the time pleasantly. He possessed great facility in composing verse, and this served as a congenial occupation during his leisure moments.

"The late Rev. John B. Tabb, the poet-priest and professor of English at St. Charles' College, was a great admirer and a warm friend of Dr. Browne. When Father Tabb died a few years ago there were few who mourned for him more than did Dr. Browne. The priest and the historian often took trips together, and were closeted for hours in heart-to-heart talks. Father Tabb, who enjoyed the reputation of being one of the leading educators in English in this country, always went to Dr. Browne whenever there was a dispute over any question in that branch, and his decision was accepted as infallible.

"Dr. Browne was a leading member of the Maryland Historical Society and of the Sons of the American Revolution, and his contributions to the historical lore of those bodies were of great value.

"An inaccuracy that aroused the resentment of the historian was the use of black and orange as the colors of Maryland. The proper colors are black and gold, he always declared with much emphasis, and was always ready to explain their heraldic significance.

His death marks the passing of another of the University's great sons to the ranks of the immortals. Dr. Browne was perhaps the most distinguished alumnus of the medical school who won his laurels in other lines, and in the world of literature and education his worth will be long remembered. Of the great company of well-known men who studied in our Alma Mater in those earlier days before the Civil War, there are now but a handful left. We mourn deeply their going, but rejoice in the work that Maryland's sons are leaving behind for the world to remember.

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Vol. VIII

BALTIMORE, MD., JANUARY 15, 1913

No. 11

## REPORT OF A CASE OF BRONCHOSCOPY FOR MULTIPLE FOREIGN BODIES (ALMOND SHELL AND PULP) IN A CHILD TWO YEARS OF AGE, WITH SOME OBSERVATIONS UPON BRONCHOSCOPY IN INFANTS AND YOUNG CHILDREN.\*

By JOHN R. WINSLOW, B.A., M.D.,

*Clinical Professor Nose and Throat Diseases  
in the University of Maryland.*

On January 5, 1911, at 2 P. M., in accordance with a telegraphic appointment, I met Dr. F. G. Wright of Chambersburg, Pa., at the University Hospital in consultation upon the case whose history follows:

Iona B., aged two years, was playing upon the floor two days previously when her mother's attention was attracted by her crying, and she noticed that the child was blue in the face and breathing badly. She immediately held the child up by its feet, slapped her back, and running her finger down the throat removed a large amount of almond shell and pulp. This resulted in greatly improved respiration, and the mother supposed that the nut had all been removed.

Since this time, however, the child has at times exhibited embarrassed respiration and occasionally cyanosis.

*Examination.* — Respiratory movements much shallower on left side and respiratory sounds lost below the second rib; no rales present; temperature,  $98\frac{2}{3}^{\circ}$ ; pulse, 118; respiration, 28; slight supraclavicular retraction on left; right lung normal.

The patient was admitted to the University Hospital and the larynx examined under cocaine

with the direct Jackson's speculum. Nothing was seen in the glottic nor subglottic space, and realizing the impossibility of passing a bronchoscope through a larynx of such size without undue force, tracheotomy was determined upon.

Meanwhile a radiograph was obtained, which, as was to be expected from the nature of the object (nut), revealed no foreign body, but only enlarged peribronchial glands.

On January 6, 1911, at 3 P. M., I performed a low tracheotomy, assisted by Dr. F. G. Wright, under chloroform anesthesia.

Immediately subsequently, with Dr. H. C. Davis in charge of the patient's head and the bronchoscopes, I passed a 7 mm. Jackson's tube into the left lower lobe bronchus, which was systematically examined. The tube was, however, too large to enter the upper lobe bronchus. A considerable amount of milky pulp was found in the bronchus and removed with mops; no shell could be discovered.

I had expected to employ suction with Killian's aspirator, in the hope of aspirating the material from the smaller bronchus, but the patient became cyanotic, the pulse weak, and oxygen and amyl nitrite had to be administered.

The bronchoscopic examination was of necessity discontinued, having occupied about 30 minutes.

The tracheotomy wound was left open, long sutures were inserted in the lip, and the nurse instructed to pull the wound open should the patient cough.

The following day (January 7) the temperature shot up to  $103.4^{\circ}$  F.; respiration, 140. Embarrassed respiration, diminished resonance, with loss of inspiratory and expiratory murmur below the second rib, were present on left side; tubular breathing was heard at left apex.

Subsequently marked cough with expectoration

\*Abstracted from paper presented to the American Laryngological Association at its Annual Meeting in Atlantic City, N. J., May, 1912.

developed. In short, the patient manifested well-marked pneumonia.

At this period Dr. C. W. McElfresh was called in consultation and placed in charge of the medical treatment of the case.

From the 9th to the 15th the patient went through the varying phases of a typical pneumonia.

On January 13 the tracheotomy tube, which had been inserted the day following the operation, was permanently removed, and the patient was able to breathe through the mouth readily.

On January 17, the thirteenth day, the patient was discharged from the hospital to return home; temperature, 97.3°; pulse, 110; respiration, 24. Tracheotomy wound nearly closed; general condition much improved. The subsequent history of the case is derived from two letters sent by Dr. Wright. The first, dated February 16, 1911, reports:

"Dear Doctor—The child is still alive, but very ill. When she first came home she was very well, except a running ear and a solid patch a little larger than a silver dollar in the left apex. It seemed as though the trouble would subside and the foreign body become encapsulated, but she developed an influenza (everyone here has it), and after a week of coughing developed a pneumonia involving at least the whole of the upper left lobe. After having the pneumonia one week the scar in the trachea opened spontaneously, and I opened the skin, allowing a free discharge. The next day she coughed up an oval piece of almond kernel about 6x3 m.m. That was four or five days ago, and she is slightly improving. If she gets well, will send full data. WRIGHT."

An extract from the second letter, dated February 29, 1912, gives the final outcome of the case:

"Dr. John Winslow:

"Dear Doctor—Today I examined Iona B. The child is apparently *perfectly well*, with no signs to show where the trouble in the chest was.

"The scar in the neck is rather broad, but the trachea seems solid. After a slow convalescence she recovered fully. Very truly yours,

"FAIRFAX G. WRIGHT."

A more unfavorable case could scarcely be imagined than this one, presenting many difficulties:

1. The child's age (two years) and under-development.

2. The nature of the foreign body, a pulpified nut, furnishing multiple particles which were splattered all over the lung surface, and doubtless entered every bronchiole.

3. The bronchus involved, the left, the most difficult to examine.

I have hesitated whether to call this a successful or an unsuccessful case. While technically I did not succeed in removing all of the foreign body by bronchoscopic methods, yet I am firmly convinced that had the nut pulp not been removed from the main bronchus, tracheotomy alone would not have enabled the child to clear its lung and survive the first pneumonia.

From a life-saving standpoint the case was most successful, and one in whose outcome everyone concerned has reason to feel gratified.

The pathologic condition in such a case is well illustrated in that reported by F. E. Hopkins (*Transactions American Laryngological Association*, 1911).

A female child, four years of age, inhaled a peanut. Careful bronchoscopic examination at two sittings failed to reveal a foreign body, and the child died on the second day.

"Autopsy showed many (24) small fragments of nuts scattered throughout the lungs and around each a pneumonic area.

"Instead of a single nut occluding the trachea or larger bronchi, the many fragments of the well-chewed nut were shot into the smaller bronchi."

Thomas Hubbard reports similar autopsy findings (*ibid.*) in a peanut case in his practice.

Cases of foreign bodies in the lungs of young children and infants (say of four years and under) are coming under our care in increasing numbers, because through the writings of Killian, Jackson, Ingals, Coolidge, Halsted, Mosher, Hubbard and other masters of bronchoscopy the general profession is being educated to recognize these conditions and their proper method of treatment.

These cases constitute the most difficult in the whole field of bronchoscopy, both on account of the small size of the respiratory passages at this period of life and the difficulties of instrumental manipulation, as well as the nature of the objects usually encountered.

While a young child is liable to place almost anything in the mouth and inhale it, owing to the small size of the glottis (6 mm. infants, Jackson; 7 mm. 3 years, Killian), large objects cannot pass through into the lower passages. Therefore, many of the foreign bodies commonest in adults are rarely found in the lungs of very young children (pieces of bone), while those encountered belong to the class most difficult of removal—small or multiple objects (nut shells, pulp, beads, pins, beans, pebbles, etc.).

The younger the child the greater the difficulty and urgency, and the mortality is high, despite successful removal. So that it has seemed to me that these cases constitute a group of themselves well worthy of the discussion of this representative body, and for this purpose I have brought the subject before you.

What is our best course of procedure in this class of cases? Should we tracheotomize at once as the primary procedure, or has the advent of bronchoscopy largely abolished the necessity for this operation?

The desirability of upper bronchoscopy (without tracheotomy) is obvious, and it should be the routine method were there no disadvantages associated with it.

In prebronchoscopic days tracheotomy was the method of choice, whose success is attested, among numerous others, by the remarkable series of four cases of foreign bodies in the bronchi of small children under two and one-half years of age, reported by our fellow, T. H. Halsted (*Transactions American Laryngological, Rhinological and Otological Society*, 1902).

In these young children upper bronchoscopy has serious objections attached to it. The anatomical structures are small, rendering the manipulation of instruments difficult and resulting in loss of time and irritation of tissues.

A study of the cases reported show that while upper bronchoscopy has been frequently attempted for the removal of foreign bodies in infants, in a large percentage, if not the majority of the cases, tracheotomy has become ultimately necessary for successful removal.

Now, if such be the situation, why not tracheotomize at once and operate by the easier and more certain route (lower bronchoscopy)?

In a recent article (*Deutsch. med. Wochenschrift*, June 29, 1911) G. Killian has made a

most valuable contribution, in which he calls attention to another aspect of this subject, namely, the frequency with which tracheotomy or intubation becomes necessary after upper bronchoscopy, *even when successful*, reporting a series of 19 cases under seven years of age, some of them personal and some derived from literature. He also cites a series of 35 cases reported by Schneider of Moscow, of which five required intubation or tracheotomy. He concludes that these procedures stand in a causal relation to upper bronchoscopy, inasmuch as the changes necessitating them occur within a relatively short period (6-37 hours) afterward; that the site of the change is the subglottic space, as evidenced by the stridor and the results of intubation or tracheotomy, and in a few cases by direct or indirect laryngeal examination.

We know from both clinical experience and post-mortem evidence that inflammatory swellings are prone to occur in the subglottic space. Children from the seventh, and especially from the fourth, year downwards are especially liable to such swellings after upper bronchoscopy.

The selection of method must be individual, depending upon a number of considerations.

1. Age of the patient. As Killian has demonstrated, it is more a matter of physical development than of age; nationality also may have a bearing. At least my intubation experiences have shown me that in certain nationalities (Italian) the larynx is smaller than the corresponding age.

Some years ago Ingals announced that he had rarely found upper bronchoscopy satisfactory in children under three years of age.

Recently Finder, *apropos* to an unsuccessful case of a piece of bone in the right bronchus of an 11-months-old child, reported to the Berlin Laryngological Society, stated that henceforth he will resort to inferior bronchoscopy in all children in the *first year* of life.

In discussing this case E. Meyer went still further, and considers inferior bronchoscopy preferable in children *six years* of age and under. Brüning advises it in all children under *two years* of age as a *routine procedure*.

Nehrkorn recommends low bronchoscopy in *all young children*.

Jackson, however, regards tracheotomy as being "unnecessary nine times out of ten," and believes that it should be limited to dyspneic cases.

I should like to know whether he intends this to apply to these very young children.

2. The *nature* of the foreign body is of great importance in determining this question.

Objects which are liable to swell so that they cannot be withdrawn through the subglottic space (beans) should be removed by the lower route (Nehrkorn, Killian).

Likewise brittle objects, which are liable to be broken into several fragments, or multiple objects, necessitating a great deal of manipulation; objects which are irritating in themselves and certain to be followed by pulmonary inflammation (peanut shells, pepper corns), should be removed without irritation of the subglottic space by instruments.

3. The *duration* of the condition is of a determining moment. The presence of a foreign body rapidly produces a catarrhal condition of the air passages in children, increasing the vulnerability of the mucous membrane to instrumental manipulation. Therefore, when the foreign body has remained for a long time, tracheotomy is indicated (E. Meyer, Killian).

4. The *side* affected must be considered, for it is much more difficult to remove a foreign body from the *left* bronchus, especially by upper bronchoscopy. Among 13 cases in children collected by Killian, in nearly two-thirds the foreign body was found in the left bronchus.

5. The condition of the *subglottis space* is of paramount importance. This should always be determined by direct or indirect laryngeal examination before undertaking upper bronchoscopy.

Any outspoken subglottic swelling constitutes a contraindication to upper bronchoscopy.

The passage of the bronchoscopic tube will inevitably result in the necessity for the tracheotomy. It is, therefore, better to perform this operation primarily and employ lower bronchoscopy.

In conclusion, it seems to me that the *present* situation with regard to foreign bodies in the lungs of *young children* has been well summarized in the advice of Hubbard: "When in doubt do tracheotomy."

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#### FIRST AID TO THE INJURED WITH SPECIAL REFERENCE TO SHOCK.\*

By ROSCOE McMILLAN, M.D. (1910).

*Local Surgeon, A. C. L.,  
Red Springs, N. C.*

*Mr. President, Ladies and Gentlemen:*

We can scarcely wonder that accidents are increasing from year to year when we stop to consider the increase in rapid locomotion of many kinds, the factories, mines, workshops, railroads, etc., all over the country. While the ratio of accidents, compared with the number of employes, is not increasing, the total number of accidents are increasing every year. A recent report from the Interstate Commerce Commission says, "Accidents on the railroad seem to be increasing steadily."

The nature of employment, surroundings and method of conducting the work determine the number of injuries. There is no doubt the actual number of fatal cases resulting from injuries will be greatly lessened by prompt and skilful treatment.

In this brief article I am exerting my energies toward railway accidents entirely. I am glad to say nearly every large railroad company has its own surgical staff. As I stand today looking into your faces, I am thoroughly convinced the Atlantic Coast Line has a very select, well-equipped and competent surgical staff, ready to meet any and all emergencies as they arise. But, gentlemen, it is a well-known fact that it is impossible for a surgeon to be delegated to every

\*Read by title before Atlantic Coast Line Surgeons Association, Richmond, Va., October 15, 1912.



train on the railroad, and as it happens all accidents do not happen at an appointed time or place when the surgeon can be at the scene of trouble. But it is possible for every road to have its responsible employes systematically taught the elementary principals of first aid to the injured, especially the great importance of controlling hemorrhage, protecting an open wound, and even so far as relieving a broken limb to some extent, pending the arrival of a surgeon. I know a lack of knowledge of some of these elementary principals is in a great measure responsible for loss of life. Every railroad should be compelled by law to carry first-aid packets on every train, and more should be placed at stations on the road. These packets should consist of at least two rubber tourniquets, a package of aseptic gauze, absorbent cotton, half dozen muslin bandages of different widths, adhesive plaster and a bottle of antiseptic tablets.

Injuries on the railroad are peculiar only in their great severity and varied character. On this account, and because of the horror so commonly preceding and attending these injuries, there is, as a rule, more shock from these than from any other class of injuries. There are few problems of more interest to the railroad surgeon than shock. In railroad accidents, where we have to deal with fractures, dislocations, lacerated wounds, etc., we have to deal with a lowered condition of all the vital functions of the body, especially of the circulatory system. It is a critical moment to see patients lying beside the track, or wherever they may be, with a small thready pulse, a lowered condition of respiration (may be full, fast or slow), blanched skin and mucous membranes, skin cold and clammy, muscles relaxed, eyes sunken, mouth half open and absolutely indifferent and careless as to their surroundings.

It is needless to say, gentlemen, the condition calls for immediate, wise and conservative action. There are several different forms of shock.

*First.*—Psychic shock. This is produced by emotion; it is a condition brought about by the terror a conscious person has of a seemingly inevitable and terrible accident. This usually precedes the injury; sometimes there is no injury at all, still the condition is found.

*Second.*—Injury to nervous system.

*Third.*—Hemorrhage causing shock.

The first thing to do in all cases is to find out what has caused the shock and try to lessen any further shock by removing the cause if possible. See at once if all bleeding has been controlled; if hemorrhage continues, this must be controlled first. Then ascertain the physical condition of patient. Inexperienced surgeons are frequently so anxious to attend to the wounds, they entirely neglect the wounded person. They go through the very long, but proper, aseptic technique necessary for the local injury, and are very much surprised on completing the dressing to find the patient is dead.

The absence of any serious wound to the head or spinal column, and the fact that no great hemorrhage has taken place externally or internally suggests psychic shock. For this form restore heat to the surface and give full doses of morphia and atropine hypodermatically, which will in a great measure diminish the urgency of symptoms.

The second and last forms are, of course, more serious and difficult to treat. The wounded surfaces should be handled very carefully on account of the psychic effect of pain; also on account of the production of dangerous shock-producing afferent impulses that attend manipulation of tissues having a nerve supply. Support the circulation; give moderate doses of strychnine, or digitalis, ammonia, caffeine, ergot, etc., frequently repeated. Each and every case must be treated as a case unto itself. Alcohol will sometimes tide over a bad case temporarily, but continued large doses do more harm than good. Support circulation mechanically by use of saline infusion; the only trouble is to obtain sterile water. If possible, use at least 500 c.c. of normal salt solution, to which at least 15 c.c. of a 1 to 1000 solution of adrenalin chloride has been added. This should be given subcutaneously and repeated as necessary. In severe cases bandage the abdomen and extremities to force the blood into the heart, head and lungs. Make patient as comfortable as possible. Secure absolute rest, both mentally and physically. Gain patient's confidence, calm his fears; if this cannot be done, use small amount of some anodyne.

I believe in delaying operations while patient's condition is not so good, but if we do delay we must see that the wound is clean. Wash it until you know it is clean, then twice as long again.

## REPORT OF FOUR UNUSUAL CASES.\*

By A. ALDRIDGE MATTHEWS, M.D.,  
Spokane, Wash.

I think it would be a good policy for members of our Society to make it a point to report cases which are interesting or unusual. There are many conditions which are acceded as being rare from the records, but in reality are as a whole common, so common that they are not worth while to make record of; the acute emergency gall bladder work, ruptured pyosalpinx, causing general peritonitis, foreign body appendicitis, other than due to fecal concretions and such.

I take this opportunity to report four cases, one of ruptured pyosalpinx, causing general peritonitis, and three cases of appendicitis, one being due to an ordinary brass pin, one to an apple seed and one pin worms. I was prompted to do so by reading articles by W. N. Buckman and R. H. Fowler, both of New York, and from whose papers I take the liberty to quote as regards statistics which they have compiled.

The first report will be the ruptured pyosalpinx, but before reporting will run over briefly some data that I have gathered on the subject.

There have been recorded but 91 cases of ruptured tubal or ovarian abscesses, causing general peritonitis, and adding my one case, making 92. While this is the first case of this character I have ever seen, although I had the opinion that it was much more common in so frequent a disease as pyosalpinx, 92 instances of ruptured tube and diffuse peritonitis are few enough indeed to warrant the belief that this complication, if not rare, is at any rate unusual. On the other hand, if one could add to these 92 the unrecorded cases, the reports buried here and there in the literature and the instances of perforation protected by localized peritonitis, the figures would be large enough, no doubt, to show that rupture is a complication too infrequent to gainsay conservative treatment of pyosalpinx, but sufficiently common to be born in mind in the management of every case of purulent tubal infection.

Of the 92 cases recorded, many were post-mortem notes, and in many the history is very meager. Therefore the literature of this lesion is not susceptible to complete statistical analysis.

Thirty-six of these cases were not operated upon, all died, and from the autopsy findings the diagnosis was made. Forty-six were operated upon, 36 recovered and 10 died.

The diagnosis of these conditions is not at all an easy matter, and one has to consider the person's history. The most common mistake is to call it appendicitis, and it can well be associated with it or ectopic gestation. The anatomic diagnosis is not essential, however, since peritonitis is usually evident; the indication for operation is therefore established.

It is of interest to note, in looking up the records of such cases, there is a history of repeated attacks of severe pain before the onset of the peritonitis, the final attack being the most severe, and followed by collapse and the peritonitis.

The diagnosis of peritonitis due to a ruptured hollow organ is easily provided by history of sudden violent pain and collapse or weakness, followed by great or entire relief of pain and the development of peritonitis signs and symptoms.

Toward the recognition of a ruptured pus tube as the source of such a peritonitis, the most important thing to bear in mind is its occasional occurrence and to consider it as about fifth in role of rupturing organs following the appendix, gall bladder, bowel and stomach. Localization of pain and tenderness low down in the iliac region, the history of gonorrhea or a recent pregnancy or uterine instrumentation fortify us, especially if there is a great tenderness and a mass or fullness in the vaginal fornix, especially if it be on the left side, where an appendix abscess is not likely to be found. If the patient is known to have had a pyosalpinx, especially if she has given such evidence of activity as repeated attack of pain, the diagnosis of ruptured pus tube is presumptive. Finally, if a previously palpated tense tube is now felt flaccid or collapsed, the diagnosis may be made with much assurance.

January 20, 1912.

*Case I.*—C. B.; female; married; age 24 years; occupation housewife; family and past history has no bearing on present condition. Has two children, both living, youngest two years old. Had a miscarriage last fall (about four months ago). Has had more or less pain in right side low down for past year, and much more noticeable since miscarriage.

Between three and four weeks ago pain became much worse, and at last menstrual period passed

\*Read before Spokane County Medical Society, November, 1912.

lots of clotted blood and pus, and since a discharge purulent in character has continued. About this time (two weeks ago) she had an attack which she thought to be influenza, the soreness in the lower abdomen and right side was worse, and she would have sweats and chills, and chilly sensations being continued up to the time of perforation.

For the past few days the slightest jar or moving about would cause considerable pain, and toward the last she could hardly walk on account of pain which would radiate across lower abdomen; along with this she had a frequent desire to urinate. Yesterday A. M. she attempted to lift her two-year-old child, and when doing so had a severe sudden lancinating pain low down in her abdomen, and she could not straighten up, the pain soon became general and the belly very tense, vomiting several times.

She called her family physician, Dr. John Kaulbach of Edwall, who referred the case to me. I saw her about 30 hours after the rupture had occurred. Her condition was most critical; pulse 120, temperature subnormal, with a facies of peritonitis; the belly was not much distended, but board-like. I held out very little hopes of her recovery to her family, for I truly believed she would die.

Vaginal examination was very unsatisfactory on account of extreme tenderness, but I could elicit a fixed uterus and a mass on right side. Patient was then transferred to the surgery, where I made a midline incision low down. There was a purulent peritonitis with a quantity of free pus in belly cavity. A general matting up of all the pelvic organs, and I broke into a large abscess; whether it was the one which had ruptured or another I was not certain, as the patient's condition did not warrant me doing anything further, as she was almost moribund, so inserted drainage tubes into the pelvis. (Might mention here that appendix was not involved.)

Patient was given 700 c.c. normal salt infusion under her breasts and put to bed in a sitting posture, with continuous saline solution by rectum, which was kept up for four days. Patient made a fair recovery, and was able to leave the hospital on the twenty-seventh day.

Shortly after leaving the hospital the old pelvic infection began to give her more trouble, and she returned February 17, 1912, and I removed both tubes (double pyosalinx) and appendix. She

had also been suffering with cramps (severe gas pains, as she expressed it), which would come and go. This was due to the intestines being very much matted, and held together by adhesions, many of which I released. She was again able to leave the hospital on the twenty-fifth day after the operation, and returned home, only to return again after about one month for intestinal obstruction due to adhesion, and she left the hospital for the third time on the twenty-fifth day after the operation, and has been well and gaining ever since, but for some time she was bothered with more or less discomfort from adhesions, especially after eating heartily. When I saw her a few days ago this had disappeared.

The three following reports are appendix cases, first due to an ordinary brass pin, second pin worms and third to an apple seed.

Statistics showing foreign bodies in general as predisposing cause of appendicitis present considerable variation. Up until 1906 foreign bodies had been found by the late George Fowler in one-fifth of 1 per cent. of 2000 cases, Murphy found foreign bodies in 2 per cent. of 2000, and Mitchell 7 per cent. in 1400 cases.

At Cook County Hospital on post-mortems of 3750 subjects Herneck found foreign bodies in the appendix in but two instances. But two cases came under Dr. Osler's observation in 10 years of pathological work in Montreal. Sharp-pointed metallic bodies represent a class by themselves; they have rarely been found in the large surgical clinics, and their occurrence represents a curiosity and the ordinary domestic pin is the most commonly encountered body of this character, and it is estimated by Barnes that out of 94 cases of true foreign bodies in the appendix, he has tabulated the pin composing 54 per cent.

One would naturally suppose that a pin would lead to a rapid perforation, but this is not usually the case, according to Fowler, and he further states that it may be found free from deposit, rusty or corroded. It may form a nucleus for a fecal concretion, and be either partially or entirely surrounded. In cases where the pin has not been entirely surrounded, it is the head that is most usually covered with soft or hard fecal matter.

*Case II.*—A. D.; age two years; boy. Child previous to this illness was strong and well. Mother noticed that when child would lie on back (making muscles of belly tense) that he would act as though it hurt him; also lifting and handling

him would make him cry, but this did not excite any anxiety with the mother until she noticed the child walked drawn over to the right side, and would lay with right leg drawn up.

Child was brought to my office on June 8, with history as above stated. Upon examining him found a distinct mass in right iliac region, very tender, temperature 101 and pulse 120, and I made the diagnosis of an appendicular abscess which had previously been made by their family physician.

I had the youngster transferred to St. Luke's Hospital and operated. Upon opening the abdomen over the mass I broke into an abscess containing two or three ounces of pus, which was gently mopped out; then I inserted my finger into the cavity and ran against something sharp, which I thought to be a needle. I did not remove my finger, but passed a forceps down and caught the pin. The appendix came up readily with the head of the pin still imbedded in it.

Appendix removed and stump inverted. The sixteenth day after the operation the youngster had obstruction symptoms, which subsided without any surgical interference, and left the hospital a short while later.

*Case III.*—School girl; age nine years. Family and past history of no interest regarding present trouble. Present trouble had existed for several months. She would complain of soreness in abdomen often and occasional severe pains that would cause her to go to bed for part of the day, and usually her mother thought she had a temperature, she having been a trained nurse.

Her family physician, Dr. J. F. Hall, who referred the case to me, saw her in this attack and one previously very much similar.

Her temperature was 101, pulse 100. There was not very much rigidity over abdomen, but a decided tenderness over the appendix region on pressure. We made a diagnosis of sub-acute appendix and advised removal, which was done March 3, 1912. Upon removing the appendix I was rather surprised not to find a more abnormal organ, so went in search for other trouble, but with no avail.

After operating, upon examining the appendix, which seemed to be moderately full and soft, it did not show any decided inflammatory condition, but was a little clubbed at the end. Upon opening it to my great surprise I found

it absolutely full of pin worms, which were very motile.

Patient left hospital on the eighth day, and Dr. Hall tells me he has relieved her by proper medication of thousands of these worms, and the girl is now perfectly well.

Case IV. There is no especial interest, except being unusual, so will not go into detail.

Male, 40 years old. History of chronic appendicitis for some time. I removed sub-acute appendix and found an apple seed and a small fecal concretion therein. Patient made an uneventful recovery.

### DIAGNOSIS OF SYPHILIS.

By E. KILBOURNE TULLIDGE,  
*Senior Medical Student.*

Today it is surprising how unerringly the diagnosis of syphilis may be made clinically without the aid of laboratory tests. However, before the introduction of the present assurative measures of diagnosis many physicians balked before placing the patient upon a long prescribed treatment extending over several years, because of the appearance of the initial sore alone, it being the usual custom to wait until the development of the secondary stage before administering anti-luetic remedies.

It has certainly been a great stride in the science of medicine that enables us today to definitely tell a man in half an hour under favorable conditions that he has the organisms of syphilis growing within his body. Owing to the tenacity with which nature guards her secrets, it has only been within the last few years that this refinement of diagnosis has been possible. It is by no means easy to distinguish the spirochete pallida from other organisms frequently found in the body; just as the Klebs-Loeffler bacillus at times is unrecognizable from other organisms that do not cause diphtheria.

There are five scientific methods employed for the diagnosis of lues:

1. The discovery of the organism itself in the body, usually ascertained by the dark field illuminator.
2. The inoculation of the organism into the lower animals, such as the ape, chimpanzee, male guinea pig.
3. The Wasserman test.

4. Growing the organism in specially prepared culture media outside of the body.

5. The skin test, Noguchi's reaction.

The first of these methods may be employed in several ways. The dark field illuminator has been exhibited for the past few years at practically all gatherings of medical men and constantly used by Dr. Timberlake in the genito-urinary department. This instrument places the spirochete in the same relation to the eye as a grain of dust bears in a ray of sunlight entering a dark room. The organism when seen in this sphere appears slender, spiral in shape, presenting from four to twelve curves, pointed at each end; it may appear increased in length, due probably to the presence of two organisms in the act of division. It is often confused with the spirochete refringens, which does not present as uniform or as many curves, and is thicker and coarser.

Another method occasionally used in differentiating the organism which may be employed with very little trouble and with satisfactory results is the one known as the Burri India Ink method. A puncture is made in the neighborhood of a chancre or condylomatous patch, antiseptic precautions being used, and the exuding fluid, with as little blood as possible, is placed on a clean sterile slide, where it is mixed with one drop of corresponding size of India ink, free from bacteria. The slide is then brushed with a piece of cardboard or cigarette paper, in somewhat the same fashion as blood is smeared for microscopic examination. Smear dries very quickly, and may be examined with an oil emersion lens. Organisms present will appear white or gray upon a blackish or slate-colored background.

The great drawback to this method is the confusion occasioned by the presence of ordinary saprophytic organisms contained in India ink not especially prepared. However, upon studying the specimen, should no other spirillum be present, it is quite safe to make the diagnosis of *treponema pallida*.

The Wasserman test has been so thoroughly discussed by the medical journals for the past year that it will be hardly necessary to go into its technique.

In inoculating the disease into lower animals the male guinea pig is the animal best to use, affording the same results, with less financial expenditure, as the monkey. The material collected from the chancre or condylomata of the suspect is

injected into the animal's testicle, which at the expiration of a week or ten days will show the presence of the spirochete if examined.

The Noguchi method is a cutaneous one, and has been well described in the journals of the American Medical Association, Vol. LIX, No. 14, dated October 5, 1912, and April 20, 1912, and the journal of Experimental Medicine, 1911, Vol. XIV, 557. The reaction is caused by the injection cutaneously of Luetin prepared from the pure killed cultures of the Luetic spirillum. This causes an eruption varying from inflammatory nodules to pustular formations lasting for several days, as a rule. The reaction may occur almost immediately, but in some cases it may commence as late as three or four weeks after inoculation.

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## THE DEVELOPMENT OF ANTISEPTIC AND ASEPTIC SURGERY.

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By EMMET JAMES STEWART,  
*Junior Medical Student.*

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The technique of wound treatment has, during the last 20 years, become more complicated by the general adoption of the antiseptic system. Much detail work has become necessary, the exact performance of which is alone a guarantee of good results. It matters not how many changes in the practical application of the method, which was first described by Sir Joseph Lister, the principle remains the same. In those days the "antiseptic method" of Lister stood forth in relief against all other methods. It was based on the germ theory of infection, and consequently the only method which in a systematic way sought to prevent the entrance of micro-organisms into wounds. In the course of development it has come about that the words antiseptic and aseptic are used in a somewhat different sense from that which they first imparted. Under aseptic conditions we attempt to destroy all living germs on hands of surgeon, on the dressings, instruments and skin of patient to be operated on beforehand, while under the antiseptic method we attempt, after operating on the patient, to destroy all micro-organism by washing out the wound with various chemical antiseptics and dressing wound with dressings which have been impregnated with antiseptics.

We would today include Lister's antiseptic methods among our modern aseptic methods. It will be

of interest in this connection to follow the changes which have taken place in the latter until the systems in use today have been developed. Not many years after Lister's publications attention was called to the great inconvenience of the spray during operations and the application of dressings. So great had been the results of wound treatment since the Listerian method had been developed, and so firm had the belief in all its details become, that it seemed a hazardous proceeding to discard anything which was deemed necessary by this method. Lister's method in regards to antiseptic sprays was based on the principal that infectious germs are everywhere suspended in the air, and that to render them harmless it was necessary to use a spray. But the drawbacks of the spray was that it drenched both patient and surgeon, it hindered close inspection by the surgeon, and it also cooled off the patient during serious operations. It was now shown that while the spray had some influence on the germs, it did not destroy their vitality. About the same time Trendelenburg, and also Bruns, had found that the results of antiseptic treatment was equally good whether the spray was used or not. So the spray was dispensed with, and this marked one step forward in the development of antiseptic surgery.

In 1885 the experimental method was for the first time applied to determine the germicidal power of various antiseptics after thorough washing with soap and water, carbolic acid, boric acid and corrosive sublimate, and other disinfectants were tested by Foster in these experiments with culture media. He came to the conclusion that corrosive sublimate alone prevented the development of germs.

Shortly afterwards Kümmel, and somewhat later Fuerbringer, repeated these experiments in a more satisfactory manner. The question whether or not sterilization of the hands soon after their contamination with septic material is possible is one of grave importance to the obstetrician and surgeon. This question was settled by Kümmel, who came to the conclusion that, under ordinary circumstances, cleaning with soap and water, followed by an immersion and rubbing in a 6-1000 solution of thymol, a 1-1000 solution of bichloride or a 3-100 solution of carbolic acid, was a sufficient guarantee for ordinary purposes.

To Fuerbringer belongs the credit of having first called attention to the fold and fissures of the

skin as places which harbor impurities, and also showed how difficult it was to dislodge the impurities by mechanical means, and, more important than this, he called attention of surgeons to the difficulty of disinfection of the fingers in the regions of the nails. He gave the following method: After cleaning the hands and nails, the nails being always cut short, the hands should be washed for one minute with soap and water, then for one minute in alcohol, and after alcohol has evaporated put hand for one minute in 1-1000 solution of bichloride or a 3-100 solution of carbolic acid.

In sterilization of instruments, according to plan of Lister, the instruments were put in a trough containing a carbolic solution 1-20. Later it was recognized that mechanical cleaning was the most important part of the process of sterilization. Dry sterilization of instruments was at first tried from a desire to prevent rusting. Redard discovered that steam under pressure at 110° C. absolutely sterilized in from 10 to 15 minutes, but that sterilization by boiling liquids could only be accomplished at a temperature of 120° C. After some experimenting he decided on a mixture of 40 parts of calcic chloride and 60 parts of water, which boils at 110° C., as a suitable medium. But he did not turn these results to any further practical use, believing in the superior efficiency of steam.

It appears that Davidsohn, a pupil of Robert Koch, first emphasized the advantages of sterilization by boiling, but to Schimmelbusch belongs the credit of first having introduced the method into surgical practice. After a series of experiments in von Bergmann's Clinic he demonstrated its efficiency and simplicity. Instead of using pure water, he recommends a 1 per cent. solution of plain washing soda. This serves two purposes—it intensifies the sterilizing power of the boiling water by removing grease and dirt from the surface of the instruments and it prevents rusting.

In regard to dressings by Lister's original method, dressings impregnated with chemical antiseptics were used. But gradually chemical impregnated dressings were discarded, and at present time they are not used, except in the case of iodoform gauze. We strive to accomplish the same end as Lister did, when he described his carbolized gauze to prevent wound infection, but we now try to do this by aseptical precaution before and during the surgical manipulation and before the dressings are applied. At the present time we

use gauze sterilized by means of heat, and do not irritate the wound by antiseptically impregnated gauze. These are some of the advances which have been made in the development of antiseptic and aseptic surgery.

## SYMPTOMS AND TREATMENT OF SHOCK.

By PORTER P. VINSON,  
*Junior Medical Student.*

Shock was probably first recognized by William Clowes in 1568, but it remained for John Hunter to give the first accurate description of the characteristic symptoms in 1784. Clowes attributed this peculiar condition to the presence of some foreign body, either in the wound or circulating freely in the blood. This opinion, with slight modifications, existed for quite a number of years; in fact, it was one of the foremost theories until the latter part of the nineteenth century, when Goltz of Strasburg made his classical experiments on the frog. When a frog was suspended with his legs downward and then tapped on the mesentery it was noticed that the heart was suddenly arrested.

After a variable length of time it began to beat again, but was much paler than before, less blood being thrown into the aorta. If the frog was now placed in a horizontal position, however, the heart assumed a natural color, there being a normal volume of blood thrown into the aorta at each contraction. This arrest of the heart was due to a vaso-motor paralysis produced by mechanical irritation. This very wonderful experiment of Goltz has been, and is today, the basis of the most widely accepted theory of shock.

Fisher accepted Goltz's conclusions, but he added that in this vaso-motor paralysis a large amount of blood accumulates in the large abdominal veins, and when this paralysis is prolonged the patient dies from anemia of the brain and overdistension of the right side of the heart, due to this unequal distribution of the circulating blood.

Shock, therefore, in its broadest meaning, may be defined as "sudden vital depression due to an injury or emotion which makes an untoward impression upon the nervous system." Surgical shock, with which we are most concerned, is the

impairment or inhibition of the vaso-motor system due to an injury.

The pathology of shock is more or less obscure. It has been studied by Hodge, who made observations on the microscopical changes in the nerve cells of dogs and cats before and after long electrical stimulation. He found that the outline of the cells were irregular, the nucleus was smaller, irregular and stained darkly; also that the cells in the cerebrum and cerebellum were decidedly smaller, and this was accompanied by an enlargement of the pericellular lymph space. He concluded that the same changes occurred during shock as during this overstimulated condition.

The symptoms depend in a large measure on the severity of the shock, this depending, in turn, on the mental condition of the patient, and may vary from a temporary faintness to a profound, continued and finally fatal vital depression.

The symptoms may come on almost immediately, or may be delayed for some time, surgical shock usually coming on during operation.

Under the severer forms of shock we recognize two types: First, the torpid type, or that accompanied with very much depression. This torpid type shows the following characteristic symptoms: Great pallor of the skin and mucous membranes; loss of facial expression; eyes dull and pupils dilated and reacting only very slowly to light; forehead covered with a cold sweat; muscular tonus markedly lessened; irregular, shallow and sighing respiration; irregular and weak heart action; diminished sensibility; subnormal body temperature, and mental torpor.

In rare cases we may have nausea and vomiting, and there may be relaxation of the sphincters, causing the involuntary passage of urine and feces.

Next we have the nervous type, or that accompanied with great activity on the part of the patient. He becomes extremely restless; tossing about in bed and crying out in delirium. The pulse is thready, or possibly almost imperceptible; the respiration is irregular and shallow.

The above-mentioned symptoms may clear up in from two to twenty-four hours spontaneously, or they may persist to such a marked degree that it requires our best attention to revive the patient.

Those symptoms arising from purely emotional causes rarely require treatment, so our attention will be confined to the treatment of "surgical shock."



We should, in all surgical procedures, first examine our patient to ascertain if there is any probability of his not being able to withstand the operation without severe shock. If we find upon examination that he is liable to suffer from shock, we should be prepared for it, and the family should be duly warned.

In weak patients we should, if possible, use a local rather than a general anesthetic, for the local anesthetic, by rendering the peripheral nerves insensible, blocks effectually the pathway for any impulse to travel to the vaso-motor center.

In case you find it necessary to use a general anesthetic, it is well to give your patient one-twentieth grain of strychnine and three grains of caffeine citrate hypodermically an hour before the operation. Hot coffee may also be given at this time.

Have the room warm and keep the patient well covered. It is a very good plan to keep the operating table warm, either by especially constructed hot-water pipes or by hot-water bottles.

Use dry gauze in preference to moist dressing. Keep the extremities well covered, and in some cases it may be well to bandage the lower limbs.

Warm whisky mixed with water, as an enema, during the course of the operation, is highly recommended.

The treatment as outlined above is preventive rather than curative in character, and when we have the active symptoms of shock manifesting themselves it becomes necessary to resort to more active treatment. In this case we should give one-thirtieth grain of strychnine and one-fiftieth grain of atropin. Normal saline solution with the addition of one drachm of adrenalin chloride solution (1-1000) should be given by hypodermoclysis, but care should be taken not to give it too rapidly nor in too great an amount.

Tincture of digitalis should be given by the mouth in 10-drop doses whenever the patient is able to take it.

In the restless cases give morphine sulphate, one-sixth grain.

Finally, we may resort to mechanical methods to revive our patient. These consist of the practice of artificial respiration and lowering the head. This latter procedure allows the blood to reach the anemic brain, and may be of very great service.

Usually our patient will react to shock without

any treatment whatsoever, but we also find cases which, even with our very best treatment, we are unable to restore to normal.

It is well for us to bear in mind this condition of vaso-motor inhibition and paralysis, and in all surgical procedures be prepared to combat in a measure its untoward and sometimes disastrous termination.

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## CERTAIN DISEASES OF OLD EGYPT.

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By EJNAR HANSEN, M.D.

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It may be doubted whether there is truth in the old saying that "medicine" is the mother of science, but at least medicine may be called a good helpmate, stretching out a helping hand in many directions, and especially to the archeologist.

Normal prehistoric skeletons have been carefully examined by medical authorities many times, and the science of anthropology is built up upon recent examinations and comparisons of the different discoveries. Only in late years and by help of an extremely well-developed microscopical and bacteriological technique has it been possible to transfer the studies to the pathological field and to take the first step in the study and description of the diseases of the old and prehistoric peoples.

Dr. J. W. S. Johnson of Copenhagen writes a very interesting account in "*Ugeskrift for Læger*" about different diseases found among the old Egyptians. Evidence of caries of bones in mummies was found several years ago, and the excavations of the burial place at Dakka in 1909 gave us much material for study and further increased our knowledge of certain bone diseases. Four out of ten excavated skeletons showed a diseased condition of the spine, and these four skeletons came from only two graves. The one grave contained skeletons of a man and a woman, both with carious destruction of small vertebrae. The other tomb contained skeletons of two men and a nine-year-old boy. One man had a kyphosis caused by the destruction of two vertebrae. The boy had five vertebrae partly destroyed and grown together in a solid mass. The microscopical examination of these cases has not yet been



published, but it seems impossible to eliminate tuberculosis as the cause.

There are here two possibilities. This is either the ravage of tuberculosis in a single family or a collection in one place of patients with this particular disease. Why the latter should be the case we do not know; therefore the first is the more probable.

Dr. Marc Armand Ruffer, president of the Egyptian Department of Health, has for a long time undertaken microscopical examinations of normal and pathological tissues in mummies. He describes his methods in *Cairo Scientific Journal* (Vol. IV, No. 40), and according to his report he found the following diseases among the old Egyptians: Arteriotherom, anthracosis pulmonum, croupous pneumonia, cirrhosis of liver, abscesses of kidneys and bladder, calcified Bilharzia eggs, and several times he has been able to prove the presence of bacteria in liver and lung tissues. In one case the liver and lungs were so filled with a micro-organism so similar to plague bacilli that the proof of plague lacked only a few abscesses. In another case he found abscesses with colon bacilli. He has not yet been able to prove the presence of tubercular bacilli.

Gibbositities seems to be rather common, and were also found in the ape mummies. We know now that many apes die of tuberculosis.

So long as the presence of tuberculosis has not been positively proven, we can only guess, as has been done in many hip diseases analogous with coxitis tuberculosa.

Dr. Ruffer found in *one* mummy spondylitis, arthritis cubiti with fistula, and an infection in the ilio-sacral joint.

Science is approaching nearer and nearer to the correct diagnosis of these cases.

Dr. G. E. Smith and M. A. Ruffer have examined a humpback mummy from the twenty-first dynasty (about 1000 years B. C.) This was found in a tomb at Deir el Bahari. The destruction was in the fourth last dorsal and first lumbar vertebrae; there was plenty of new bone tissue; the spinal column was very much bent, and the point of the angle was made of the eighth and ninth dorsal vertebrae. In the right side was found a broad flat intumescence spreading downwards and outwards into the right fossa ilica. There were no fistulae in the skin; the intumescence was at the place of the psoas muscle.

A more detailed account of this case by the above-named doctors and an introduction by Dr. K. Sudhoff can be found in "*Zur historischen Biologie der Krankheitserreger*" (Vol. III).

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In writing to Mrs. Hemmeter concerning the illness of Professor Hemmeter, Carl Anton Ewald, professor of medicine at the University of Berlin, says in German:

"Undoubtedly he has worked too much again, but I am glad to know that everything is being done to save this active and brilliant mind to us and to American medicine. But absolute rest for a mind that is so much in love with work is a very difficult matter to enforce, and you will have to have patience with him. I am very glad and comforted to know from the latest reports that he is improving. I congratulate him and you on his election as honorary member of the German Physiological Society."

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Among the University alumni practicing in Kentucky are:

Lexington—Abram L. Blanding, class of 1881.

Louisville—Henry R. Carter, class of 1879, Surgeon U. S. P. H. and M. H. S., Marine Hospital.

Richmond—C. J. Bales, class of 1878.

Russellville—John K. W. Piper, class of 1893.

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Among the University alumni practicing in Louisiana are:

Coushatta—Wm. A. Boylston, class of 1871.

Haughton—John E. Rooks, class of 1905.

New Orleans—Wm. Henry Block, class of 1895, 832 Canal street; Wm. Buford Clark, class of 1882, 1301 Magazine street.

Shreveport—Emmet A. Welsh, class of 1887, Levy Building.

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Among the University alumni practicing in Iowa are:

Carlisle—Wm. Edgar Sperow, class of 1894.

Des Moines—David Wilson Smouse, class of 1876, Knights of Pythias Building.

Sabula—Franklin D. Ayers, class of 1892.

Shenandoah—Lynn J. Putnam, class of 1909.

Waterloo—Ernest J. Waddey, class of 1891, Lafayette Block.

# THE HOSPITAL BULLETIN

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NATHAN WINSLOW, M.D., Editor

BALTIMORE, JANUARY 15, 1913.

THOMAS FELL, A.M., Ph.D., LL.D., THE  
NEW PROVOST.

At the meeting of the Board of Regents, held Tuesday, January 9, 1913, upon the recommendation of the committee appointed for the purpose of selecting a Provost in place of the late Bernard Carter, Dr. Thomas Fell, President of St. John's College, Department of Arts and Sciences, was chosen for the position. Undoubtedly the selection will meet with the approval of every alumnus, as Provost Fell is an educator of wide experience and in touch with modern educational methods. The University is to be congratulated upon its choice, and is indeed fortunate to have such a man at its head. For the first time in the more than one hundred years of its existence the University of Maryland has a real head; as a consequence of which we can confidently look forward to the institution taking on new life and expanding into new fields of usefulness. This appointment marks an epoch in our history, a passing of the old order of events and the celebration of a new birth. Our dreams for a better and greater University of Maryland, we feel assured, will now come true. During the past decade there has been a gradual change of view by those in charge of the destinies of our Alma Mater. Some were too discouraged to perceive it, but others had stout hearts, and sincerely believed that the Board of Regents were alive to the necessities for change in the method of conduct of the affairs of the institution. Their faith has been justified, and undoubtedly will be further rewarded by still greater changes in the organic

reorganization of the institution in the near future. Remember, in the meantime, however, that a transition is on, and that the authorities need your help, sympathy and encouragement. Do not expect of Provost Fell too much in the beginning. Give him time to become thoroughly acquainted with the affairs of the institution, and THE BULLETIN predicts that he will evolve a new institution upon the framework of the old.

For the present it is planned that Dr. Fell will open an office at the University and give Saturdays and at least two afternoons a week to the institution as an entirety. It is also proposed to have an office force to assist him.

Dr. Fell is regarded as one of the leading educators of this part of the country. His ability as an administrator has been tried as the president of St. John's College. In the opinion of all who have watched the growth of that institution under his leadership, he has been remarkably successful.

When he assumed charge of the old institution, which was founded in 1696 and thus ranks as one of the oldest colleges in America, a great deal of its prestige had been lost, and there was danger that it would suffer the same fate as a number of other small colleges had.

With signal ability Dr. Fell set to work to restore St. John's to its former position. When he took charge there was a long-standing mortgage of \$30,000 hanging over the school. Through his efforts that has been entirely wiped out. The final accomplishment of his administration was the merging of St. John's with the University of Maryland.

Dr. Fell was born in Liverpool, England, July 15, 1851. His father was a surgeon in the English Army, and was killed in the Crimean War. Dr. Fell was educated at the Royal Institution School of Liverpool and at King's College, London. He later entered the University of London, and then studied for a year at the University of Munich. He came to America in 1882, and in 1884 was elected professor of ancient languages at New Windsor College, New Windsor, Md. In 1886 he was elected to the presidency of St. John's College, being the twelfth president of its now 123 years of existence. St. John's College has conferred upon him the honorary degree of doctor of philosophy, and the University of the South that of doctor of civil law, while Hampton-Sidney College has honored him with the degree

of doctor of laws. His standing as an educator is recognized everywhere. Dr. Fell is a member of the American Philological Association, the National Educational Association, the Phi Sigma Kappa Fraternity, the University Club of Baltimore, and the Clisophic Society of Princeton University.

The formal induction into office of Dr. Fell should be made a memorable occasion. No stone should be left unturned to make it as impressive as possible. The event, in our opinion, is of greater importance than our recent centennial celebration, as it marks a new departure in the career of the University of Maryland, and should, therefore, be celebrated befittingly.

We have no patience with those who cry, "We have permitted our opportunity to pass." Opportunity knocks more than once at every gate; it is knocking at ours now.

"They do me wrong who say I come no more

When once I knock and fail to find you in;

For every day I stand outside your door,

And bid you wake and rise to fight and win.

Wail not for precious chances passed away;

Weep not for golden ages on the wane;

Every night I burn the records of the day;

At sunrise every soul is born again.

Laugh like a boy at splendors that have sped,

To vanished joys be blind and deaf and dumb;

My judgments seal the dead past with its dead,

But never mind a moment yet to come.

Though deep in mire, wring not your hands and weep;

I lend my arm to all who say 'I can!'"

This is an opportunity; let us help Provost Fell to grasp it.

#### THE HOLIDAYS—GIVING AND RECEIVING.

The college exercises closed on December 21, and were resumed on January 3. We hope that all students and teachers alike have enjoyed the respite from classes and have returned to their work refreshed and invigorated. The Yuletide is, for most of us, a time of good cheer; a time of family gatherings and of social festivities. It is also a time for sharing with others, of giving and receiving. However pleasant it may be to receive gifts, we believe "it is more blessed to give than to receive." The writer personally does not

feel that he is entitled to eat a bountiful Christmas dinner without having in some measure helped to bring good cheer to others less fortunate than himself. We give presents to our families and friends, and receive tokens of love and esteem from them in return. The same custom might be appropriately established between institutions of learning and their children and friends. The college gives far more to its pupil than it receives in financial returns. The young man receives instruction, training, inspiration and opportunities that are of the greatest use to him. For these, mayhap, he pays a moderate charge and then calls the account square. But the account is not settled; institutions, like individuals, require financial assistance, and to whom can they turn for help, with the same expectation of receiving it, as to their own alumni, who have been nurtured and strengthened and sent on their way to battle with and overcome the obstacles that confront them?

The University of Maryland has given much and has received but little. There is urgent need for at least five endowed chairs, but at present we are endeavoring to raise funds for but one department, that of pathology. We need \$100,000 for this purpose, and have about \$20,000 in hand. Friends and fellow-alumni, the need is great. Will you not help us, in such measure as you can, to raise this fund?

#### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	81 84
1873.....	491 83
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	252 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00

1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	115 00
1899.....	55 00
1900.....	215 00
1901.....	270 00
1902.....	330 00
1903.....	340 00
1904.....	135 00
1905.....	220 00
1906.....	175 00
1907.....	110 00
1908.....	20 00
1909.....	15 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to Jan. 1, 1913. . \$10,372 17

NEW SUBSCRIPTIONS IN DECEMBER, 1912.

Randolph Winslow, 1873.....\$50 00

## ITEMS

It is with much pleasure that we acknowledge receipt of a paper from Dr. Najib Kenawy, class of 1905, of Alexandria, Egypt, upon the subject of gastroenteritis. He says that at this time the physicians of Egypt are having much discussion as to the proper method of treatment, and tells in his paper about treatment by hypodermic injections of sea water. This will be published in THE BULLETIN within the next few months.

Among the University alumni practicing in Arizona is:

John Holt Lacy, class of 1879, at Miami.

The following alumni were among those who successfully passed the examinations of the State Board of Medical Examiners in December, and to whom licenses to practice have been issued: Drs. Bernard Mark Berngartt, James Archie Duggan, William Edwin Gallion, Jr., Moses Randolph Kahn, John Charles Norton, John Andrew Skladowsky, all of the class of 1912, and Dr. Isidore Isaac Hirschman, class of 1911.

We are glad to announce that Dr. William Tarun, class of 1900, who has been away for some time owing to ill-health, has sufficiently recovered to return to Baltimore and resume his practice.

Among the University alumni practicing in Alabama are:

Birmingham—Joseph Thomas Coulbourn, class of 1886, Woodward Building; William Groce Harrison, class of 1892, Empire Building; Howell Towles Heflin, class of 1893, 109½ N. 20th street; Devotie Dennis Jones, class of 1872, 5602 Second avenue, South; E. Laurence Scott, class of 1906, Woodward Building; Lewis Green Woodson, class of 1887, Woodward Building.

Childersburg—Thomas Jefferson Powell, class of 1866.

Dadeville—Eugene Walker Hart, class of 1891.

Equality—James Columbus Cousins, class of 1891.

Roanoke—William Gibson Floyd, class of 1878.

Dr. William Fulford Sappington, class of 1901, of Webster's Mills, Pa., visited the hospital December 13, bringing a patient for operation. Dr. Sappington has had 20 cases of typhoid fever recently under his care.

Dr. Isadore Isaac Hirschman, class of 1911, who recently passed the State board examiners, is connected with the State Sanatorium at Sabillassville.

As we go to press we are informed that the council on education of the American Medical Association has rated the University of Maryland as a Class A school.

Dr. Nathan R. Gorter, class of 1879, of 1 W. Biddle street, has been appointed Health Commissioner of Baltimore, succeeding the late Dr. James Bosley. Dr. Gorter was born in Baltimore county, Maryland, April 25, 1860, son of Gosse Onno and Mary Ann Polk Gorter. His father was descended from early Dutch settlers, and his mother's family was of Scotch-Irish origin. He was educated in the Anne Arundel County Academy and the University of Maryland. Since graduation he has practiced in Baltimore, and has won an enviable reputation both as practitioner

and a teacher. He filled in 1884 the chair of surgery in the Baltimore Polyclinic. From 1898 to 1904 he was surgeon to the Cambridge Hospital, and since 1894 he has been consultant in surgery to that hospital. He is a member of the Medical and Chirurgical Faculty and the American Medical Association. He is a member of St. Paul's Protestant Episcopal Church, and belongs to the Maryland and Baltimore Country Clubs, the Baltimore Athletic Club and the Bachelor's Cotillion Club. He married May 4, 1898, Miss Mary Gordon Norris.

In the Health Department Dr. William Royal Stokes, class of 1891, has been bacteriologist for many years, and will retain that position.

After his appointment Dr. Gorter said:

"I was much pleased when the late Dr. Bosley was reappointed by the Mayor, and deeply regret that he was not spared to fill out his allotted time.

"When the present vacancy occurred many of my friends were kind enough to express their wish that I should be appointed Health Commissioner, and when Mr. Preston tendered me the position I felt it was a public duty which I should accept.

"The Mayor is deeply interested in the development of the Health Department, fully realizing that the health of the citizens of Baltimore is the fundamental factor in the development of our city. His wish is to have one of the most up-to-date departments of health in the country, and I know we will have his most hearty co-operation in the continual development of our department.

"I fully realize the responsibility of directing the department, which has as its duty the safeguarding of the health of the citizens of Baltimore, and my first duty will be to thoroughly familiarize myself with the working of the integral parts of the Health Department.

"I ask and confidently expect the hearty co-operation of the medical profession and of the citizens of Baltimore in the continued upbuilding of this very important department of the city government."

The engagement is announced of Miss Lucy Perry, daughter of Mrs. S. M. Perry, of Atlanta, Ga., to Dr. Emmett O'Brien Taylor, class of 1911, of Greelyville, S. C. The marriage will take place in the early spring. Dr. Taylor wrote us recently and said that he enjoys reading the BULLETIN. He adds the following, which may

comfort some of his classmates in the same boat: "I am not getting rich down here, but am getting three square meals a day and a goose-hair bed to sleep on at nights. That's not bad, after all. You bet I get my share of the spoils. How could a U. of M. man do otherwise?"

Dr. Henry R. Carter, class of 1879, senior surgeon of the United States Public Health Service, has been placed in charge of the United States Marine Hospital in Baltimore. Dr. Carter is a native of Virginia, and attended the University of Virginia three years, and then entered the University of Maryland, graduating in 1879. He entered the United States Marine Hospital Service the same year. He was the first officer of the service to receive a commission to go to Panama after the United States took control of the hospital. He took a foremost part in the work of making the canal region a fit habitation for American men. His work in the yellow fever epidemics of 1893, 1897, 1898 and 1899 is known everywhere, and the first instance in the far South where an epidemic of yellow fever was suppressed was when he was working in Southern Mississippi in 1898. For four and a half years he was director of hospitals in the Canal Zone, and recently located at the Government Hospital in Louisville, Ky., from where he came to Baltimore to take the place left vacant by Dr. W. P. McIntosh, who has been transferred to Louisville, Ky. Dr. Carter has been stationed in Baltimore twice before. The University is glad to welcome him to Baltimore, and considers that his work will always be linked with Finlay's in connection with pioneer work in yellow fever.

## UNDERGRADUATE NOTES

*Under the Supervision of E. Kilbourn Tullidge.*

At a meeting of the senior class, the remaining offices were filled as follows: Honor committee, T. Ruffin Pratt, chairman; Manly Coke Smith, Vertie Edward Edwards, Frederick R. Devine, William Tillman Martin; sergeant-at-arms, Edgar E. Travers; poet, Frederick Leonard McDaniel; associate editor of Old Maryland, Charles Reid Edwards.

Mr. John Thomas Beavers of the senior class, who was operated on in the University Hospital

early in January for chronic appendicitis, is now convalescing and will soon be out again.

Mr. Franklin Dashiell Murphy of the senior class was operated on for imperfect nasal septum late in December. Although the operation proved successful, he has been suffering intensely from shock.

Among the new men entering the hospital as clinical assistants is Gerard Le Bret, who, it will be remembered, was confined to bed in the hospital during the greater part of his last year's session.

Everyone is anxiously awaiting the publication of the 1913 *Terra Mariae*, which is under the direction of Editor-in-chief Earle Griffith Breeding of the senior class. Mr. Breeding informs us that the book will be, both in size and contents, larger and better than in former years, and consequently a higher price will have to be asked. It will be ready for publication about the first of May. Copies will be reserved for those making a deposit of \$1 with Mr. Breeding.

At a meeting of the clinical assistants, the executive committee appointed the following men to arrange for the annual house dance to be held on Friday evening, January 17, 1913, at Albaugh's Parlors: Messrs. Earle Griffith Breeding, Harry C. Raysor, Robert Raymond Sellers, H. W. Butler and Norbert Charles Nitsch. Invitations have been extended to the internes and members of the senior faculty.

Mr. George Ward Disbrow, class of 1913, was operated on in the hospital on January 8 and is now convalescent.

Manager H. H. Warner of the basketball team states that though the squad has been under the direction of Professor Pennington of the Central Y. M. C. A., it has exhibited poor showing, which Mr. Warner states is due to the lack of support and co-operation on the part of the faculty of the various departments of the University. The members of the team complain that they are unable to obtain leave of absence on days of practice, and are thus handicapped. "Practice makes perfect" is an old maxim, and

if we expect to turn out a team worthy to represent the University we must give them an opportunity to practice. The games played and the scores are as follows:

Seton Hall College—At South Orange, N. J., 42-21.

Columbia University—At New York, 41-16.  
City College of New York—20-18.

Georgetown University—At Washington, D. C., 20-18.

Loyola College—At home, 21-16.

In the Georgetown game, Peters (law, 1915) and Peppers (law, 1915) showed excellent speed and clever passing. It will be noted, however, that the University lost in each game, although they were much improved in the later games.

The remaining games will be played with Swarthmore at Swarthmore on January 10; Mt. St. Joseph's, at Baltimore Y. M. C. A., January 15; Catholic University, at home, and Georgetown University, at home.

The line-up is as follows:

*Forwards*—Peters (law, 1915), Gavis (law, 1915), Timanus (medical, 1914).

*Center*—Hughes (dental, 1915).

*Defense*—Thomas (medical, 1916), Peppers (law, 1915).

*Substitutes*—Gardner (pharmacy, 1913), Zimmerman (law, 1915).

## MARRIAGES

Mr. and Mrs. Albert G. Tews announce the marriage of their daughter, Miss Gertrude Hedwig Tews, University Hospital Training School for Nurses, class of 1909, to Mr. Lewis S. Cole of Jessups, Md. The couple will be at home after February 1 at Jessups. Mrs. Cole is a native of Germany.

Dr. Frank Sidle Lynn, class of 1907, and Miss Clyde Clayton Dawson, University Hospital Training School for Nurses, class of 1908, were married in Norfolk, Va., on Saturday, December 14, 1912. The ceremony was performed at the Hotel Monticello by Rev. William Cox, a cousin of the bride. Mrs. Lynn is a native of Griston, N. C.

Dr. William A. Ellingwood, class of 1908, of Winterport, Maine, was married on November

28, 1912, to Miss Ruth Anne Kellam of Onancock, Va. The ceremony was performed by Rev. L. M. Betty at the home of the bride's sister, Mrs. J. C. W. Leatherbury, and immediately afterwards the couple left for their home in Winterport. Mrs. Ellingwood is a graduate of the Woman's College, Lynchburg, Va. Dr. Ellingwood was for a time after his graduation resident physician of the Presbyterian Eye, Ear and Throat Hospital of Baltimore.

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Miss Mary Dorsey Mitchell, daughter of Dr. Alexander Mitchell, class of 1877, of Glencoe, Md., was married on Saturday, January 11, to Mr. Warren Keach Magruder of Baltimore. Mrs. Magruder was operated on at the Baltimore Eye, Ear and Throat Hospital on Friday night, and left the Hospital to be married in Emmanuel Church, returning there immediately after the ceremony, although she will be out in a few days.

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Dr. Moses J. Fine, class of 1910, surgeon of the steamer Voltunro of the Uranium Line, was married to Miss Lillian Eilman of 183 Bergen street, Brooklyn, in Knights of Pythias Hall, 432 Hopkinson avenue, Brooklyn, on December 31, 1912. Dr. Fine's fiancée had decided that if the marriage could not take place in 1912 she would wait until 1914, for she would not "tempt fate" by a wedding in 1913. Dr. Fine's ship came to Brooklyn from Rotterdam, and the trip was exceedingly rough, and time after time the gales retarded the steamer's progress. When the boat docked at Halifax, several Halifax physicians offered to take his place so he could proceed to New York by rail, but he stuck to his post, and although the ship was two days late, won the race with time, and was married two hours after the boat reached port.

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## DEATHS

Dr. Benjamin T. Winchester, class of 1875, died at his home in Windsor Hills, January 14, 1913, after an illness of 10 weeks, aged 62 years. He was born in 1851 in Queen Anne's county, the son of I. W. and Josephine R. Winchester. Dr. Winchester was educated in the Van Metter-Monroe private school in Carroll county, later entering the medical school of the University of Maryland.

After his graduation he went back to Queen Anne's county to practice, remaining there till 1888. Then he came to Baltimore and established the Winchester Manufacturing Co., manufacturing largely his own preparations. This company was recently absorbed by Sharp & Dohme. He married Miss Alice Bryan, daughter of William R. Bryan, of Queen Anne's. He is survived by his widow and two sons, Clifford B. and William Valentine Winchester, all of Baltimore, and a brother, Julian R. Winchester, and a sister, Mrs. Julia W. White, both of Queen Anne's.

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Dr. Alfred B. Giles, class of 1880, of Forest and Callaway avenues, was stricken with an attack of the heart while taking a bath, and died shortly afterwards. He called to his wife to bring some aromatic spirits of ammonia. She hurried to the bathroom and found him unconscious. Dr. Arthur L. Fehsenfeld, class of 1909, was hurriedly called, but by the time he reached the house Dr. Giles was dead. Dr. Giles was 50 years of age, the son of the late Judge William P. Giles, and was well known in the Walbrook and Forest Park section of the city. He is survived by his wife, Mrs. Georgia Giles, and one son, John Steward Giles.

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It is with the deepest regret that we announce the death of Dr. Oliver Parker Penning, class of 1897, of 1711 St. Paul street, on December 28, 1912. Dr. Penning has been ill for several years, and his death was not unexpected.

Dr. Penning was born in Darlington, Harford county, Maryland, January 26, 1869, the son of S. E. and Alice Markland Penning. He was graduated from the Havre de Grace High School in 1886, and later entered the University of Maryland, graduating in 1897. He was for a time clinical assistant in the University laboratory. From 1898 to 1899 he was resident physician of the University Hospital, and from 1902 to 1904 assistant demonstrator of anatomy and assistant in surgery. He was a member of the Medical and Chirurgical Faculty of Maryland, the University Hospital Medical Society and the Baltimore City Medical Society. He was president of the Splint Club, and of the Landmark Lodge of Masons, St. John's Chapter, Crusade Commandery.

Death was due to splenomyelogenous leukemia. With him at the time of his death were his

mother, Mrs. Alice Markland Penning; his sisters, Mrs. John Coulbourne and Mrs. Joseph E. Goodwin, and his brother-in-law, Mr. Coulbourne. The funeral took place from his home on Tuesday, December 31. Services were conducted by Rev. Walter Haupt of Havre de Grace, and interment was in Greenmount Cemetery. The honorary pallbearers were Drs. George H. Cairnes, class of 1864; William I. Messick, class of 1895; William J. Coleman, class of 1908; Joseph W. Holland, class of 1896; Frank Martin, class of 1886, and St. Clair Spruill, class of 1890, all of Baltimore.

The active pallbearers were Drs. Henry B. Thomas, class of 1888; Howard E. Ashbury, class of 1903, and J. Royston Green, class of 1899, and Messrs. J. C. Taliaferro, Hugh L. Pope and Lynn R. Meekins.

Dr. Penning was of an extremely lovable disposition, and will be greatly missed in the University set. He was a loyal alumnus, and was always interested in every move made for the good of the University. By his death the University has lost a firm supporter. We extend our deepest sympathy to Dr. Penning's family.

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We also regret to announce the death of Dr. Richard C. Massenburg, an alumnus of the class of 1884, a Confederate veteran, a physician of the old school, and, above all, a man of the very highest type. Dr. Massenburg was a credit to his school and to his profession, and was loved by all who knew him.

He was born in 1845 in Hampton, Va., the son of a druggist there. Later his parents removed to Macon, Ga., where his father for many years conducted a drug business under the name of Massenburg & Son, an older brother of Dr. Massenburg being the partner. At the age of 17 he entered the Confederate Army, and at the close of the war returned to Macon, later returning to his original home in Hampton. After spending several years there he came to Baltimore and entered the Maryland University, graduating in 1884. Dr. Massenburg located at once in Towson, where he has been ever since. He conducted a drug store in connection with his practice. Of late years his son, George Yellow Massenburg, was associated with him, but gave up pharmacy to study medicine, graduating in 1911. Dr. George Massenburg was for a time resident physician at

the Church Home and Infirmary, and recently has been a resident physician in the Government Hospital at Ancon, Panama. He was on his way home at the time of his father's death, but did not reach here until after the funeral.

Dr. Richard Massenburg was one of the principal organizers of the Baltimore County Medical Association, and was for years secretary of this association.

He was a member of the old Towson Guards, and later of the First Regiment, Maryland National Guard, retiring with the title of major. He was devoted to the interests of the South, and the Confederate flag was always in evidence in his home on festal occasions, and he loved the air of Dixie.

At the time of his death Dr. Massenburg was health officer for his district. He married Miss Carrie Lee, daughter of the late Wesley Lee of Towson. He is survived by his wife and his son, Dr. George Massenburg, and one daughter, Mrs. H. Courtenay Jenifer of Towson.

He was buried on New Year's Day from his home. Services were conducted by Rev. Dr. W. H. H. Powers of Towson. The pallbearers were all members of the Baltimore County Medical Association, and were Drs. William L. Smith, Harry M. Slade, class of 1884; James F. H. Gorsuch, class of 1876; Harry S. Jarrett, Josiah S. Bowen, class of 1903, and Richard F. Gundry. He was buried in Prospect Hill Cemetery, Towson.

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Dr. Thomas Clinton Baldwin, class of 1894, died at his home in White Hall, Baltimore county, Maryland, January 3, 1913, of Bright's disease. Dr. Baldwin was 44 years of age. He was born at Baldwin, Md., and attended lectures at the Baltimore Medical College, later entering the University, graduating in 1894. After his graduation he located at Stewartstown, Pa., where he built up a large practice. Later he removed to White Hall, and was for some years health officer for the Seventh district. During his life he also practiced for some years at York, Pa., where he was Health Commissioner. He married Miss Ella McDonald, who survives him. Three sons—Bruce, Donald and Maurice Baldwin—also survive.

He was buried on January 6, 1913, from Center Presbyterian Church, White Hall, and burial was in the cemetery adjoining the church.



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## SOME RECENT TUBE CASES.

By RICHARD H. JOHNSTON, M.D.,  
*Associate Professor of Laryngology in the University of Maryland, Baltimore, Md.*

In September, 1912, I was asked by a physician to see his little daughter who, a week previously, had swallowed a penny. The father, thinking that the foreign body would pass through, paid no special attention to the incident until the mother noticed that the little patient was having difficulty in swallowing and that she would awake several times at night fretting with pain in her throat. The father then had X-ray pictures made, which showed a shadow at about the seventh cervical vertebra, or at the upper end of the esophagus. The patient was taken to the University Hospital, where she was immediately prepared for operation. The preparation in these cases is very simple. The patient is taken to the operating-room in her street clothes and wrapped in a sheet which is securely pinned so as to reduce movements of the arms and legs to a minimum. She is then placed on the table with the head straight and not over the end of the table. An assistant holds the head while the arms and legs are attended to by a nurse. No anesthetic is used; this point cannot be too strongly emphasized since cocaine is dangerous and ether is unnecessary, except possibly in those cases in which the foreign body has sharp edges or happens to be a pin. The patient was placed on the table as above described; with the head held straight, Jackson's modified child's laryngoscope was passed; this tube measures 17 cm. in length and 10 mm. in the inside diameter. When the larynx was reached the spatula end of the tube was hooked around the cricoid cartilage, which was easily raised and the upper end of the

esophagus exposed. The penny was immediately seen lying slightly posterior to the middle line with edges transverse. Forceps were introduced through the tube, the penny seized and promptly removed. The operation did not take two minutes. The little patient was not hurt, the membrane was not injured, and ten minutes after the operation we took her home in her father's automobile. She made an uneventful recovery. I have described this case in detail to emphasize the value of the straight position of the head and the advantage of using a short instrument in upper esophagoscopy. This combination makes esophagoscopy easy and practically free from danger. For four years I have used the straight position of the head in direct laryngoscopy, and for some time in upper esophagoscopy in children, but only recently have laryngologists adopted it to any extent. It simplifies the work, and I find that as my experience increases I am able to work oftener without anesthesia, local or general.

*Case II.*—In September, 1912, Mr. S., 39 years old, was referred to me by Dr. J. F. Hempel. The patient had always led an active life and had been a powerful man. His normal weight was 186 pounds. Three months before I saw him he noticed that certain foods did not seem to pass down as well as formerly. The difficulty in swallowing increased rapidly, and when I saw him at the Presbyterian Hospital it was painful to see the muscular contractions of the face and neck when he attempted to swallow milk. His weight was 143 pounds. His throat was so sensitive that, even after the injection of morphine and atropine, my attempt to examine him under local anesthesia failed. The next day in the presence of Dr. Murphy of Cincinnati and Dr. Arrowsmith of Brooklyn, we examined him under ether anesthesia and found a hard, firm stricture about an inch below the cricoid cartilage. The smallest

Bunt's bougie was passed through the esophagoscope and coaxed through the stricture. We then found a second and a third stricture, both of which were successfully dilated. The next day the patient swallowed milk. Because of the three strictures, it has been difficult to pass a French bougie, but with a Bunt's bougie the esophagus has been kept open, so that the patient now eats everything. He has gained 13 pounds and feels well and strong. We expect to use French bougies shortly. This case is reported because benign stricture at the upper end of the esophagus in adults is rare, and because of the successful treatment of the three strictures by a simple method. One of the interesting features of the case was that no cause could be found for the obstruction. It may be well to emphasize the dangers of cutting and forcibly divulsing benign strictures of the esophagus. In an experience of five years I have had no bad symptoms from the use of Bunt's bougies except pain or soreness for a few days after the first treatment. In children I use the two smallest, and in adults the three smallest bougies at the first treatment. No attempt is made to force the stricture for fear of setting up fatal mediastinitis. If after the first treatment, a small French bougie will not pass easily, recourse is had to Bunt's bougies again. These are passed every five days until all swelling has subsided and no blood appears. Then the French bougie is tried again and usually passes without trouble. The patient is then taught to pass the bougie, which he uses at home regularly for a time and later every six months. I have always believed that cutting benign strictures or trying to force dilatation by powerful divulsors through the esophagoscope is dangerous, because we have no means of knowing just what we are doing. With graduated olive points beginning with 1 mm. we can always tell what the dilatation will be. One can swallow through a small opening, and it is not necessary to try to produce a lumen equal to the normal esophagus. I have kept in touch with all my stricture cases, and, except for the slight trouble of passing the bougie every few months, they are all well.

*Case III.*—In July, 1912, a boy, seven years old, was brought to me from Crisfield, Md., with the history of having inspired a grain of corn four days previously. His breathing was labored, temperature was 102 degrees and pulse 120. The patient had a hoarse, croupy cough; the respira-

tory murmur over the right lung was almost abolished. The boy was taken to the Presbyterian Hospital, ether was administered and the bronchoscope passed with the head straight on the table. My experience with the straight position of the head convinces me that the bronchoscope is more easily passed than with the head over the end of the table, as is advocated by most operators. After the patient is anesthetized, the separable speculum is passed and the larynx brought into view. The bronchoscope is then passed through the laryngoscope, and with a gentle, twisting motion slips between the vocal cords. The laryngoscope is removed while an assistant steadies the bronchoscope; the head, which together with the body is raised on cushions, is allowed to drop to the plane of the table; the operator takes his seat at the end of the table and pushes the tube further down, controlling the movements of the head with the free hand. In this method it is remarkable how little extension of the head is necessary for successful work. No assistant is required to hold the head over the end of the table, and the operator has a comfortable seat which enables him to work more quickly. In very young children the cushions are used, but the head is dropped before the bronchoscope is passed. The grain of corn was located wedged in the depths of the right bronchus; it was seized with forceps and removed. The patient recovered promptly. The grain of corn was swollen twice its natural size.

*Case II.*—A little boy, two years old, inspired a watermelon seed two weeks before I saw him. He had a croupy cough and his temperature was elevated. He was placed on the table and the larynx examined with the head straight. Nothing abnormal being found, a 5 mm. tracheoscope was passed, and as soon as it was pushed between the vocal cords the foreign body was seen. Because it was so slippery, it was grasped with difficulty, but was finally removed. After the operation edema of the glottis developed and a tracheotomy had to be done. He wore the tube four days, and after its removal made an uneventful recovery. I wish to emphasize the case with which the larynx can be examined in children with the head straight on the table. The position is the same as for upper esophagoscopy described above. The instrument is the same and is introduced as easily in infants as in older children. Anesthetics are never used. For the removal of foreign bodies or papillomata in the larynges of

children, the method is far superior to extension with the head held over the end of the table. The greatest advantage of the method is that no trained assistant is required, since the head can be held properly by anyone. The great disadvantage of the "Boyce position" is the fact that one must have special training to hold the head just right.

*Case V.*—This case illustrates the ease with which tumors may be removed from any part of the larynx in adults with the right instrument and the proper position of the head. For a long time I have been doing direct laryngoscopy in the sitting position with the head straight, which gives the advantage of complete relaxation of the neck muscles. This position, with the use of the instrument described above or the small, separable speculum, makes it possible to examine and operate in all larynges with ease. Most direct laryngoscopes are too large, and to make the work more difficult are introduced between the incisor teeth. Under these conditions, unless the patient has a long neck and small teeth, it is practically impossible to see the entire larynx without pulling so forcibly on the speculum as to cause pain. If, perchance, the operator sees the growth, he is in such a cramped position successful removal is very difficult. These difficulties are removed and the examination made almost as easily as with the mirror by using the small speculum and passing it between the right or left bicuspid teeth with the head straight, or nearly so, and turned slightly to right or left. The tube is carried quickly down, the end hooked around the epiglottis and the entire larynx exposed. Practically no force is exerted on the instrument and often its weight exposes the larynx. The instruments that I use are made with separable handles, so that the vertical part of the handle can be removed when one wishes to examine a patient in the prone position. The patient was a man, 30 years old, who, four years ago, had a papilloma removed from the left vocal cord by the indirect or mirror method. For three years his voice was clear. About a year ago huskiness made its appearance, and this was soon followed by hoarseness. Because of a large uvula and an overhanging epiglottis, a satisfactory mirror examination was impossible. A growth, apparently on the left vocal cord, was seen, and to this I attributed the hoarseness. Following my usual custom, I anesthetized the larynx with 20 per cent. alpin solution for examination and operation

through the direct laryngoscope. The result of the examination shows how superior the tube is to the mirror in patients with a low-hanging epiglottis. The patient was seated on a low stool with head straight and turned slightly to the right. The small 10 mm. tube was introduced between the left bicuspid teeth and passed down to the epiglottis, which was hooked forward, exposing the larynx. The tumor, which was indistinctly seen with the mirror, proved to be under the cord and not on it. On the right false cord a large tumor mass, extending down over the true cord and preventing proper approximation of the cords, was seen. This growth was causing the hoarseness. With Pfau's universal handle and different cutting tips, the masses were quickly removed. Some of the growth was attached to the right cord and a small tumor was located in the anterior commissure. After removal alcohol was applied. These applications will be continued some time to destroy any small particles which may be left.

The apparent difficulties connected with direct laryngoscopy, bronchoscopy and esophagoscopy have prevented many laryngologists entering these fields. Instead of trying to simplify the work, it seems to me that new instruments are being introduced, which tend to greater difficulties for the beginner. With a few instruments one can do successful work. For the larynx no tube is as satisfactory as the small, modified Jackson model with the light at the end. For bronchoscopy many laryngologists prefer the Bruening's hand light, because the light carrier in the Jackson tube is liable to become clouded with blood or mucus. This objection is overcome by having a second carrier loaded to introduce if occasion demands. I can handle the Jackson tube with greater ease and prefer it for that reason. For upper esophagoscopy in children no instrument is better than the modified Jackson tube, because of its ease of introduction with the head straight. The only objection to it is that one cannot see far ahead of the tube because the light is not strong enough. I have tried all manner of tubes, and have come back to Jackson's models because I think they are the simplest and easiest to handle. When one learns direct laryngoscopy by simple methods, bronchoscopy and esophagoscopy are easy. As the work is simplified it becomes more and more fascinating. It will never reach its highest grade of development for the

greatest number, however, until simplicity of methods and instruments is insisted upon.

I have notes of three more cases which are of some interest.

A male, 54 years old, was referred to me with the history of trouble in deglutition of five years' duration. His trouble was peculiar, in that food which had been swallowed 24 hours before would come up entirely undigested and almost in its original state. Sometimes for days he would swallow perfectly. The continued lack of nourishment pulled him down from a strong healthy man to a mere shadow. At times pain was severe. Before the examination he was given morphine and hyoscine hypodermically. The esophagoscope was easily passed and nothing found until the cardia was reached. Here two distinct openings were seen, one of which to the left led into a pocket two or three inches in depth, which was filled with milk and undigested food. After pumping the pocket out the mucous membrane could be seen. To the right the puckered appearance of the cardia was distinct. To enter the diverticulum the upper end of the esophagus had to be carried to the right. When the pocket was emptied the walls immediately collapsed, so that the opening was difficult to find. The esophagoscope was easily pushed into the stomach.

Some weeks ago a man came to the University Hospital with the history of having swallowed almost nothing for three weeks. He had had trouble for a long time; there were times when he could swallow without difficulty. But for three weeks he had vomited constantly. At the request of Dr. Zueblin I examined his esophagus under deep ether anesthesia. Local anesthesia was deemed inadvisable, because from the man's highly nervous state we thought of a cardiospasm. Repeated attempts to pass a stomach tube had failed. The esophagoscope showed that the upper part of the esophagus was normal. When the cardia was reached the examination of its walls showed no pathological lesion, and the case with which the tube was pushed into the stomach made the diagnosis of cardiospasm. The pink mucous membrane of the stomach contrasted strongly with the pallor of the esophagus.

In July, 1912, I was consulted by Miss R., 30 years old, for a stubborn cough of six months' duration which had followed "grip." She had taken all the usual cough remedies with only temporary benefit. A bronchoscopic examination

showed inflammation of the trachea, which so often is a sequel of "grip" and which can usually be cured by the application of silver nitrate 2 to 10 per cent. solution. Six applications relieved the cough entirely.

Before closing I wish to refer briefly to a case of papillomata of the larynx in a child. Before the introduction of the direct laryngoscope, such cases were always a bugbear to the laryngologist. So difficult of treatment were they that splitting the larynx was advocated by some of the more radical throat surgeons, and the operation was done with impairment, if not ruin, of the voice, because in small larynges it is difficult to approximate the two halves properly or so much tissue is destroyed by this radical procedure. The treatment now is along logical lines, thanks to the direct laryngoscope. I have no hesitancy in saying that it is never necessary to open the larynx for the removal of these growths, and that it is rare that a tracheotomy has to be done. It is, however, better to perform the latter operation if the child is in danger of suffocation, because the larynx can be cleaned out in two or three sittings through the direct laryngoscope and the tracheal tube removed permanently. The patient was a child, 19 months old, referred to me by Dr. A. M. Shipley for aphonia of several months' duration and attacks of cyanosis, especially on crying. At the University Hospital the boy was pinned in a sheet and examined with the direct laryngoscope, the head being held straight on the table. The diagnosis of multiple papillomata was made and most of the growth at once removed through the tube with Pfau's forceps. Two such operations resulted in the complete removal of the tumors. Applications of alcohol were made to the larynx once weekly, with the result that the growths disappeared completely, and up to this time—one year after the first operation—have not returned. This result is exceptional, for most cases have to be treated several years. I mention this case simply to condemn laryngotomy in the treatment of tumors of the larynx, except, of course, in malignancy.

*Appendix.*—Recent experience has convinced me that the high frequency spark is the best treatment for papillomata of the larynx in adults and in children. In a patient, 67 years old, with a large papilloma of the right laryngeal surface of the epiglottis, two applications of the spark a week apart caused the total disappearance of the

growth, so that in a month it was impossible to tell whence it had sprung. The microscope did not show malignancy, but such growths in old people are practically the precursor of cancer from degeneration if they are not promptly and radically removed. The spark is applied through the direct laryngoscope after anesthetizing the membrane with alypin (20 per cent. solution). In my work I use the spark about a quarter of an inch long, because with this length it is under absolute control. In multiple papillomata in children it is just as easily applied through the direct laryngoscope without anesthesia by holding the head straight on the table. The tumors are burned with the spark, turn pale and disappear. The normal tissue is not injured unless the spark contact is prolonged.

807 North Charles street.

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#### PREPARATION OF PATIENT FOR OPERATION.

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By GEORGE LOUTRELL TIMANUS,  
*Junior Medical Student.*

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When patient enters hospital for operation, a thorough examination is held, and any abnormal conditions are treated by regular routine methods.

Patient is disrobed and placed in a clean bed with hygienic surroundings.

Methods used in different hospitals will be read at end of this sketch, and contain most information that could be obtained on the subject.

The most important issue is the preparation of the site of operation. This is a most difficult process to render skin absolutely sterile, due to the existence of hair follicles and ducts of sebaceous and sudoriferous glands which present crevices for the lodgment of myriads of micro-organisms.

The process of sweating is one of the most efficient means of rendering the skin sterile. The longer this is continued the more perfect is the sterilization.

Infection is the outcome of fertilization, and it is the surgeon's endeavor to limit the infective substance, thus accomplishing septic results.

Infection is rare where large amounts of fluids are used, provided the same are sterile, due to the

dilution of the toxins. It is therefore better, if this is true, to apply plenty of sterile water than so many chemicals.

The hair on the site of operation should be removed. This is accomplished by shaving the parts after the application of soap and water. This will also remove scales of the skin and oil that may be present on the surface. Care should be taken in shaving not to cause any scratches, thus offering sites for infection.

Dr. W. E. Dreyfuss has given an efficacious method for the removal of hair. The mixture is as follows: Barii sulphid, 25 parts; saponis pulvis, 5 parts; talci veneti pulv., 35 parts; benzaldehydi, q.s. Take 1 oz. of powder, add 3 oz. of water; apply paste thickly with shaving brush; allow to remain five minutes, then with a sponge and sterile water moisten, and at the end of another five minutes wash off mass; hair will come away with water applied.

After hair has been successfully removed, wash parts thoroughly with tinctura of green soap and sterile water. Gauze or a rubber sponge should be used in the washing. Do not use a brush. Parts should be handled gently. Ether should next be applied, but should not be allowed to remain, for it boils at temperature of the body, and may burn the part. This will dissolve all remaining fats and oils present. Wash ether away with alcohol, and then cover parts with sterile gauze, over which is placed a pad of cotton and bandages sufficient to hold in place.

Monyhan cleanses skin with soap and water, then applies a compress and allows same to remain 24 hours. This compress is composed of 2-3 layers of lint soaked in a 1 per cent. formalin solution, a 1-60 part carbolic acid solution or a 1-2000 bichloride of mercury. The two latter solutions are apt to cause irritation. A second washing is given after 24 hours.

If there are any cracks or fissures in the skin, these should be rendered sterile with carbolic applied with a cotton swab, and the acid neutralized after a few minutes' application with alcohol. The actual cautery may be applied for this purpose.

The room in which patient is confined should be regular in temperature, and not too hot.

The body should be covered with a sterile sheet. Hair should be wrapped in a sterile towel. A shirt opening in the back is best, so it can be easily

removed. Long linen stockings should be placed on the patient.

#### CHOICE OF ANESTHETICS.

There are certain symptoms present in different individuals who are presented for operation which contraindicate the use of certain drugs or anesthetics. In diseases of the kidney ether is likely to cause suppression of the urine and thus cause coma and death. In diseases of the respiratory tract, as asthma, emphysema, bronchitis, the vapors of ether are very irritating and likely to aggravate the condition. In operations on the face and mouth, where it is impossible to keep patient anesthetized, in certain sensitive mucous membranes of the respiratory tract irritation to same may cause rapid rate of respiration and cough in anesthesia. All of these conditions are contraindications to ether, and are best treated by chloroform.

In any disease of heart, chloroform is always contraindicated, and ether should be given.

Some people cannot take ether or chloroform. These should be given nitrous oxide, which will render patient unconscious within 30 seconds to 2 minutes. There are no after-effects. Ether is often preceded by nitrous oxide.

A. C. E. mixture, or 3 parts of ether, 2 of alcohol and 1 of chloroform, is sometimes given.

In the giving of anesthetics the simplest methods possible are those most employed. The clothing should be loose about neck and body should not be in cramped position. Patient lying on back with arms folded across chest. Tongue should be kept forward.

#### LOCAL ANESTHESIA.

These are many in number. The application of cold to a part, spraying of ether to part or combination of ether, chloroform and menthol. The application of ethyl chloride, otherwise known as keleno, to the part to be anesthetized is a satisfactory method. Part becomes reddened, then white. These methods are, however, only fit for skin operations.

Hydrochlorate of cocaine, discovered by Keller of New York, either applied locally by dropping, as in operations on the eye, or by the subcutaneous injection a per cent. of  $\frac{1}{2}$ -2 is the agent most frequently employed for this purpose. An Esmarch bandage applied above the point of

injection will prevent cocaine intoxication, and will at the same time increase anesthetizing power. Before injecting the cocaine the parts to be injected should be rendered sterile, also the instrument used. The needle should be pushed in deeply and fluid expelled on withdrawal of needle, most being deposited directly beneath the skin.

Corning in 1885 described a method of injecting 8-15 m. of a 2 per cent. sterile solution of cocaine in the sub-arachnoid space. Anesthesia usually extends as high as the umbilicus and may go as high as the nipples. This will allow operation on the lower extremities, as well as on the organs of the pelvis, uterus, bladder, ovaries, etc.

*University Hospital.*—Routine in preparing patient for operation: Patient on entering put to bed, mouth or rectal temperature taken, pulse and respiration. Leucocyte and red blood cell count taken; hemoglobin and clotting test performed; thorough urinary and physical examination of patient, laying stress on heart, kidneys and lungs, is made.

Night preceding operation give patient light supper; 8 P. M. 1 oz. of castor oil; 6 A. M. next morning give enema. If restless during night, give opiates to quiet patient. Next morning give no breakfast, not even water.

Before going to operating-room give  $\frac{1}{4}$  gr. morphine and 1/150 gr. of atropine. Place patient on table, examine teeth to see if false and try to find any other foreign bodies in mouth. Lips, nose and eyelids greased with cold cream and eyes are hermetically sealed with a thin sheet of rubber, over which is placed a pad of wet cotton, and then anesthetic is started.

As soon as patient is fairly well asleep the field of operation is shaven and then thoroughly cleaned by washing with soap and sterile water for 15 minutes. Then all remaining soap and fatty secretions are dissolved out by the application of ether, which is in turn washed off by alcohol. A pad saturated with 1-1000 of bichloride is then placed over field. Sterile towels are then placed around point of incision and patient is covered with sterile sheets.

*Hopkins.*—Routine treatment of patient for operation: Starting at noon the day before operation, no dinner is given; that is, no solid

foods, but a light diet of liquids. One ounce of Epsom salts is given. At night an enema of water and glycerine, 3 oz. of each. Next morning another enema and, if necessary, another before operation. Patient is compelled to drink large quantity of water, it being quickly absorbed and will often prevent necessity of catheterization. Patient may have ounce of sherry or cup of strong coffee if desired before going to operating-room.

Before patient is removed to operating-room, a hypodermic of  $\frac{1}{4}$  gr. of morphine and  $\frac{1}{120}$  of atropine is given. The evening before operation patient is washed and field of operation shaven. Just before operation, field is washed with benzine and painted over twice with a  $3\frac{1}{2}$  per cent. solution of iodine.

If patient has not been washed the day before, do so before operation with alcohol and soap; no water is used.

Dr. Cullen of Hopkins suggests shaving to be done in operating-room to prevent worry of patient. That in acute appendicitis cases never give cathartic or enema. Never give calomel the day before; it is too irritating.

*City Hospital.*—Routine treatment of patient for operation: The diet up to 24 hours of operation should not include anything that is very indigestible, but patient should have fair amount of food. Evening before patient is given a full bath and field of operation scrubbed and shaven. A laxative should be given evening before operation.

Morning of operation a soap and water enema is given. Before operation patient is given  $\frac{1}{60}$  gr. of atropine; no morphine. It is said same seems to make patient sick after anesthetic. If female, a vaginal douche of 1-4000 bichloride, followed by sterile water, is given. After anesthetic is started, field of operation is again scrubbed with soap and water. Gauze is better than a brush for this purpose. Soap is thoroughly washed off and ether is applied, which is in turn washed off by alcohol. A piece of gauze saturated with a one to two thousand bichloride solution is then applied and allowed to remain until incision is made.

We would appreciate it very much if some of our readers could give us the addresses of Dr. Howard Steele Holloway, class of 1903, and Dr. Lafayette Lake, class of 1906.

## BOW-LEG—GENU VARUM.

By A. SCHAPIRO,  
*Junior Medical Student.*

Typical genu varum is the result of external bowing of the femur and of the leg bones. The maximum curve is generally near the knee. Bow-leg may be the result of lateral bending of the leg bones alone, the femur being unaltered. An anterior curvature of the tibia gives another form of bow-leg. Operative correction is demanded in all severe cases. Before the age of four or five years mild deformities may be corrected by mechanical appliances; after that age operation affords the only prospect of cure.

### METHODS OF OPERATING.

(1) *Linear Osteotomy.*—Note which bone or bones are most seriously affected. Usually in typical genu varum both the femur and tibia are badly curved. Note which part of the individual bone is most bent; it is this point which must be divided.

(a) If osteotomy of the middle third of the femur is indicated, make a vertical incision through the soft parts down to the bone on the outer or antero-external side and proceed as in supra-cordylar osteotomy, in this case, however, cutting the bone from without inwards.

(b) If the tibia is most affected incise vertically the soft parts down to the bone over the inner surface of the bone at the point of greatest curvature. Introduce the osteotome and then turn it transversely to the bone and divide the cortical bone of the inner and outer sides of the tibia, and especially that of the anterior margin. Be careful not to injure the anterior tibial vessels and nerves which lie close to the outer surface of the bone. Fracture the posterior layer of the cortical bone by manual force. Forcibly fracture or bend the fibula. If this is impossible, palpate the fibula and make a small incision down to it through the soft structures of the outer side of the leg. Introduce a very narrow osteotome and divide the bone.

(c) If femur and tibia are both markedly curved, operate on both at the same sitting.

The object of the surgeon is to over-correct the deformity. If division of one bone is insufficient, then divide the other as well. If this is insufficient, repeat the operation at whatever places it may be needed or demanded. MacEwen has per-

formed ten osteotomies on the same patient at the same sitting and obtained a good result.

2. Cuneiform osteotomy is particularly suitable in cases of anterior curvature of the tibia. Render the limb bloodless. Apply an elastic constrictor.

(1) Make a longitudinal incision down to the bone over the most prominent part of the tibia. This cut need not be much larger than the width of the chisel, as the wound in the soft parts can easily be made to slide in various directions to expose different portions of the bone. Reflect the periosteum with the soft parts. Keep the wound open with retractors.

Step 2.—With an ordinary chisel outline the base of a wedge by cutting through the cortical bone. This base corresponds to the apex of the angular deformity and should be smaller than that which is believed to be needed. With the chisel cut through the cancellous bone and remove a wedged-shaped portion of bone. Do not cut through the whole thickness of the bone; the posterior undivided portion, corresponding to the apex of the wedge, is easily fractured by manual force. Straighten the limb. If sufficient bone has not been removed, it is easy to slice off more with a chisel until the minimum amount, which permits of correction, has been removed. If the fibula interferes with the correction, the fibula must be bent or broken by manual force or divided with an osteotome.

Style 3.—If the wound tends to gap introduce a few sutures. Apply aseptic dressings. Immobilize. It is well to elevate the limb for 24 hours or longer. Subsequent treatment same as for simple fracture.

3. *Oblique Osteotomy*.—In some cases, especially of anterior curvature of the tibia, where there is much shortening, oblique division of bone permits of elongation. To attain elongation it may be necessary to lengthen the tendo achillis by means of any one of the well-known methods.

#### 5. *Osteoclasis*.

(a) Manual.—Grasp the bone affected above and below the point of the greatest curvature and bend it straight and produce a fracture. In the very young a green stick fracture is a desirable lesion to produce. It is often necessary to support the point of greatest convexity on a padded wedge of wood before sufficient force can be applied. It may be necessary to produce multiple fractures.

(b) Instrumental.—The necessary fracture or bending may be more precisely and definitely produced by an osteoclast. Probably Grattan's osteoclast is the best. Place the limb in the instrument in such a fashion that the movable arm is applied to the point of greatest convexity, while the opposite or concave side of the limb is supported by two parallel fixed arms of the osteoclast. By means of the screw make a movable arm press against and fracture the limb. By whichever means the limb is straightened, it must be fixed in good position by plaster of Paris or apparatus and treated as an ordinary fracture. In the treatment of bow-legs osteotomy and osteoclasis seem to give about equally good results.

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The condition of Dr. Charles Wellman Mitchell, dean of the medical school of the University of Maryland from 1897 to 1900, and professor of children's diseases and associate professor of medicine at the same institution, who has been dangerously ill of the grip at his home, 9 E. Chase street, is said to be much improved. Until the appointment of Dr. Ernest Zueblin last fall Dr. Mitchell was full professor of medicine at the University. He is popular among the student body as well as the faculty of the University and the staff of the hospital.

The Baltimore *Sun* has the following to say regarding Dr. Mitchell:

"He is a member of the modern school which holds to the tenet that a physician can never afford to give up his books. Like many others in this country, he acquired an excellent knowledge of German many years ago, and by that means he keeps in close touch with the latest discoveries in the profession in Berlin, Vienna and the other centers of learning in Austria and Germany. He has taken courses at some of the German universities.

"He was a classmate of Woodrow Wilson at Princeton, and, although he has never made a stump speech in behalf of Governor Wilson, he has spoken forcefully of him wherever he has gone. Dr. Mitchell's writings are marked by their purity of English, lucidity of style and thorough grasp of his subject."

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Dr. J. Holmes Smith, Jr., class of 1905, has been commissioned an assistant surgeon in the United States Public Health Service.



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NATHAN WINSLOW, M.D., Editor

BALTIMORE, FEBRUARY 15, 1913.

## THE NEW PROVOST AND HIS PREDECESSORS.

As has been announced, Thomas Fell, LL.D., D.C.L., president of St. John's College, has been elected Provost of the University under salary and with executive functions. This is an important step in the history of this institution, as the Provosts hitherto have been unsalaried officers, whose duties have been nominal rather than actual. Those who have occupied this position in the past have been men of the highest standing in the State and nation. Hon. Robert Smith, Secretary of the Navy, Attorney-General and Secretary of State, respectively, was the first Provost, serving from 1813-1815. He was succeeded by Right Rev. James Kemp, D.D., S.T.D., Episcopal Bishop of Maryland, who served from 1815-1826. The Hon. Roger B. Taney, LL.D., Chief Justice of the Supreme Court of the United States, was Provost from 1826-1839. Dr. Ashton Alexander, a prominent physician of Baltimore, was Provost from 1839-1850. He was followed by Hon. John P. Kennedy, LL.D., Secretary of the Navy in 1852, soldier, lawyer, statesman and scholar, who served as Provost from 1850-1870. Upon his death Hon. Severn Teackle Wallis, LL.D., a distinguished lawyer, eminent citizen and gifted orator, was elected to the vacant chair, which he filled until his death in 1894. Mr. Wallis is well remembered by graduates of the University between 1870-1894, as most of them received their diplomas from his hand. The next incumbent was Bernard Carter, LL.D., formerly a professor in the Law School, and recognized as

the leading lawyer of the State. Mr. Carter served from 1894 to his death in 1912.

The times have changed, and it has become necessary that we should change with them. An active head of the University has become a necessity, and Dr. Fell, the eighth in lineal succession, is the first to assume actual executive functions. Let us all, therefore, uphold his hands in every effort for the good of the University.

## THE PATHOLOGICAL ENDOWMENT FUND.

The pathological endowment fund is not increasing as rapidly as is desirable; fortunately in one way or another it does grow. Our efforts have been somewhat relaxed recently; we must brace up and go at it again.

Don't be backward, boys! Step up to the captain's office and pass over the coin! If you can't give much, give what you can!

### CONTRIBUTION BY CLASSES.

1848.....	\$50 00
1864.....	20 00
1868.....	10 00
1871.....	35 00
1872.....	81 84
1873.....	491 83
1874.....	5 00
1875.....	5 00
1876.....	115 00
1877.....	10 00
1880.....	5 00
1881.....	252 00
1882.....	310 00
1883.....	40 00
1884.....	40 00
1885.....	235 00
1886.....	100 00
1888.....	50 00
1889.....	100 00
1890.....	175 00
1892.....	150 00
1893.....	40 00
1894.....	135 00
1895.....	155 00
1896.....	52 00
1897.....	80 00
1898.....	115 00
1899.....	55 00
1900.....	215 00

1901.....	270 00
1902.....	330 00
1903.....	340 00
1904.....	135 00
1905.....	220 00
1906.....	185 00
1907.....	120 00
1908.....	20 00
1909.....	15 00
1910.....	50 00
1911 Terra Mariae.....	3 50
1912 Club Latino Americano.....	25 00

Total subscriptions to Feb. 1, 1913. \$10,392 17

#### NEW SUBSCRIPTIONS IN JANUARY, 1913.

M. C. Freilinger, 1906.....	\$10 00
W. C. Gordon, 1907.....	10 00

Total .....\$20 00

#### THE NEW RATING OF THE MEDICAL SCHOOLS.

The Council on Medical Education of the American Medical Association has published its estimate of the standing of the various medical colleges of this country. We are pleased to announce that after a careful inspection by a joint committee of three, from the Council on Medical Education and the Association of American Medical Colleges, we have been placed in Class A.

The task of elevating the standard of medical education and of crushing out the unfit schools goes on relentlessly. By merger and dissolution the number of medical schools has been reduced from 160 in 1904 to 116 in 1912, and several other mergers and closures are announced as likely to occur in the near future.

Such agencies as the New York Board of Education, the Council on Medical Education, the Association of American Medical Colleges and the various State Examining Boards are exerting a powerful influence, both potential and moral, on medical education, and those schools that cannot or will not come up to modern requirements will be forced to close their doors.

The fact that we are in Class A does not mean that we can rest satisfied with our present condition, but in every way we must continue to advance. It will be one of the first duties of the new Provost to try to raise funds for the endow-

ment of the medical department. Without endowment the modern medical school cannot exist much longer. We need \$500,000 to put us thoroughly on our feet. Who will help us to get it?

#### ITEMS

Dr. James D. Love, class of 1897, 501 Laura street, Jacksonville, Fla., announces to his patients and his friends in the medical profession that his practice is now limited to the diseases of children.

Dr. Joseph Firey, class of 1910, is located at the Medical Building, Portland, Ore.

Dr. William C. Terry, class of 1912, of Hamlet, N. C., writes us as follows:

"I am very much interested in the University and its alumni, and want to keep in touch with the happenings of the old University."

Dr. Terry is building up a fine practice, and was recently appointed assistant surgeon to the Seaboard Air Line, local division. Hamlet is a new and growing town of 3500.

Dr. Moses J. Fine, class of 1910, surgeon of the Steamer Vulturro of the Uranium Line, can be reached at 1893 Bergen street, Brooklyn, N. Y. Dr. Fine spent his honeymoon in Norfolk, Old Point, Washington and Baltimore. While in Baltimore Dr. Fine dropped in the hospital to greet his old acquaintances.

Dr. Henry Frederick Vinup, class of 1909, 1221 Hollins street, has been appointed assistant surgeon of the Fourth Regiment, Maryland National Guard, to succeed Dr. J. Harry Ullrich. Dr. Vinup is health warden for the Eighteenth Ward. He reported promptly at the armory and vaccinated the officers and men of Major Albert S. Gill's battalion.

Dr. Louis Mines Allen of Winchester, Va., was a recent visitor to the University Hospital.

Dr. A. D. McConachie, class of 1890, who was chief surgeon of the Maryland National Guard during the administration of the late Governor Crothers, is being mentioned for a position as assistant surgeon in the Fourth Regiment to succeed Dr. E. A. Smith. Dr. McConachie was a

brigadier-general on the staff of the late Governor Crothers.

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Dr. Rupert Blue, class of 1892, Surgeon-General U. S. P. H. S., and well known for his work in eliminating plague from western coast cities of America, will deliver lectures at the University on tropical diseases. Others who will lecture during this course are Dr. Henry R. Carter, class of 1879, Surgeon U. S. P. H. S., the yellow-fever expert; Dr. Charles Wardell Stiles, and Dr. James Archibald Nydegger, class of 1892, Surgeon U. S. P. H. S. Dates for these lectures will be announced later.

Dr. Henry R. Carter is a native of Virginia, studied at the Universities of Virginia and Maryland, and entered the (then) Marine Hospital Service the year of his graduation, 1879. His service has been almost entirely in sanitary work, especially in connection with yellow fever. During the yellow-fever epidemics of 1893, 1897, 1898 and 1899 Dr. Carter did yeoman service. In McHenry, Miss., in 1898, an epidemic of yellow fever was suppressed for the first time in the history of the world, once the disease had gained headway. Dr. Carter's work in this instance has been copied with success in recent epidemics. In 1910 the University conferred upon Dr. Carter the honorary degree of doctor of laws. Dr. Carter is now stationed at the Marine Hospital at Baltimore, and we are very glad the students are given this opportunity to hear him.

Dr. Rupert Blue was born in South Carolina in 1868. He was graduated from the University of Maryland in 1892, and became an interne in the Marine Hospital Service during the same year. The following year he was commissioned Assistant Surgeon, and promoted to the grade of Past Assistant Surgeon in 1897 and Surgeon in 1909. He was commissioned Surgeon-General of the Public Health and Marine Hospital Service January 13, 1912, which appointment was won by noteworthy and meritorious service, especially evidenced in the suppression and eradication of bubonic plague in San Francisco in 1907, which work brought him instantly into such prominence that his fitness for the position of Surgeon-General could not but be recognized. Dr. Blue recently spent some time in Europe studying preventive medicine as practiced there, and in 1910 graduated from the London School of Tropical Medicine. In May of the same year he was de-

tailed to represent the Public Health and Marine Hospital Service at the International Congress on Medicine and Hygiene at Buenos Ayres, and while there took advantage of the opportunity to study possible routes by which plague and yellow fever might be brought into the United States from South America. His last detail before his appointment as Surgeon-General was at Honolulu to act in an advisory capacity to the Hawaiian Board of Health and other departments of the Territorial Government to inaugurate a program to reduce to a minimum the introduction and spread of yellow fever or plague in the Territory after the opening of the Panama Canal. The students of the University will recall Dr. Blue at the time that the honorary degree of doctor of science was conferred upon him in 1909 by his alma mater.

Dr. Stiles is a graduate of the University of Leipzig, class of 1890, and the University of Paris, class of 1896. He has done much work in the investigation of the hookworm disease in North Carolina, and will talk to the students along that line.

Dr. Nydegger entered the Marine Hospital Service July 1, 1892, and was commissioned a Surgeon February 4, 1899.

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Dr. Eugene B. Howle, class of 1910, is located at 123½ Fayetteville street, Raleigh, N. C.

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Dr. William Culbert Lyon, class of 1907, has been commissioned an assistant surgeon in the Medical Reserve Corps, United States Army.

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There will be three more meetings of the University of Maryland Medical Society this season.

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Dr. Isaac Cockey Dickson, class of 1897, who has been very ill with peritonitis, has recovered sufficiently to resume his practice.

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Dr. Frank Paul Firey, class of 1910, is located at Northwest Building, Portland, Ore.

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Dr. Nathan Ryno Gorter, class of 1879, 1 W. Biddle street, has recently been appointed Health Commissioner of Baltimore to succeed the late Dr. James Boslev. Dr. Gorter was born in Bal-

timore county, Maryland, April 25, 1860. He is the son of Gosse Onno and Mary Ann Polk Gorter, and on his father's side is a descendant of Dutch ancestors, and on his mother's side of an old Maryland Scotch-Irish family. He was educated in Anne Arundel County Academy and at the University of Maryland. Since his graduation Dr. Gorter has practiced in Baltimore, and, while his practice has been general, he inclines strongly to surgery, in which branch he has gained an excellent reputation, and is one of the best-known physicians in the city. Dr. Gorter is a brother of Judge James P. Gorter of the Supreme Bench of Baltimore City. The late "Al" Gorter was another brother. Thirteen years ago he married Miss Mary Gordon Norris of Baltimore.

It is not expected that Dr. Gorter will make any changes in the department. Dr. William Royal Stokes has served as bacteriologist for many years.

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Dr. Roscoe C. Carnall, class of 1905, is located at Ballsville, Va.

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Dr. John Samuel Fulton, class of 1881, 2211 St. Paul street, has been appointed secretary to the State Board of Health to succeed Dr. Marshall L. Price, who recently resigned. In accepting this office, which pays \$2500 a year, Dr. Fulton gave up a \$5000 place in Washington. The members of the State Board are highly elated over Dr. Fulton's acceptance, and believe with him as the guiding head of the department it will embark upon an exceptionally bright future. The *Evening Sun* had the following to say upon his selection:

"The State Board of Health has made an excellent choice in selecting Dr. John S. Fulton as secretary, and the public is to be congratulated on his acceptance. Nearly the whole of Dr. Fulton's professional life has been devoted to the study of questions connected with public hygiene, and he brings to his work not only expert knowledge and training, but genuine personal enthusiasm for its duties. Such a position requires sound judgment as well as special equipment, and Dr. Fulton's record appears to show that he possesses this happy and necessary combination of practical sense and scientific attainment."

In accepting such a position, Dr. Fulton simply comes home again, as he is distinctly a Marylander. He was educated in this State, graduated from her oldest medical institution, served her many years as a private practitioner in the counties, and then in Baltimore, and was from 1896 to 1907 secretary to the State Board of Health, and therefore well acquainted with the work to which he is returning. He was for several years editor of the *Maryland Medical Journal*, and afterwards became secretary-general of the International Congress of Tuberculosis; and with the unusual combination of a personal knowledge of county and city practice and State and National and international public health work comes to the work he resigned in 1907 better equipped for it, possibly, than any other health board secretary in the country, and THE BULLETIN joins with the *Evening Sun* in congratulating the public upon Dr. Fulton's acceptance.

Dr. Fulton was born in 1859, at Fremont, O., oldest son of Rev. William Fulton, D.D., of Glasgow, Scotland, and Nancy Organ Fulton of Cable, O. He came to Maryland in 1863 when his father became rector of All Hallows Parish, Snow Hill, Md., in 1869. He entered St. John's College, Annapolis, in 1872, graduating in 1876; then entered the office of Stephen P. Dennis, M.D., Salisbury, as a student of medicine, and taught in the public schools for two years. He graduated in medicine at the University of Maryland in 1881. In 1888 Dr. Fulton married Nancy Helen White of Salisbury, Md.

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Dr. Alvin Clay McCall, class of 1910, is located at Rocky Mount, N. C.

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Mrs. Ethel Palmer Clark, superintendent of the University Hospital Training School for Nurses, and a graduate of the class of 1906, was recently elected president of the Maryland State Association of Nurses.

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Dr. Alexander Ross Mackenzie, class of 1910, is located at Peytonia, W. Va.

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At the recent meeting of the Alumnae Association of the University Hospital Training School

for Nurses the following officers were elected to serve for the coming year :

President—Miss Clara E. Query, class of 1905.

First Vice-President—Miss Mary Gavin, class of 1908.

Second Vice-President—Mrs. Page Edmunds, formerly Miss Millicent Geare, class of 1905.

Secretary—Miss Jane R. Garner, class of 1911.

Treasurer—Mrs. Nathan Winslow, formerly Miss Margaret K. Massey, class of 1903.

Executive Committee—Miss M. E. Rolph, class of 1895; Mrs. Frank Lynn, formerly Miss Clyde C. Dawson, class of 1908; Miss S. A. Howstrawer, class of 1908, and Mrs. Ethel Palmer Clark, class of 1906.

By request, we publish the following list of the class of 1908, with their present locations, so far as we are able to ascertain :

Charles Rhodes Anderson, Gare, Frederick county, Virginia.

James Leland Anderson, Main street, Greenville, S. C.

James Hugh Bay, Havre de Grace, Md.

Joseph Francis Barry, ———.

Thomas Malcolm Bizzell, Goldsboro, Wayne county, North Carolina.

Grover Cleveland Bolin, Neeses, Orangeburg county, South Carolina.

Morris Ramsay Bowie, Somerset, Gunnison county, Colorado.

William Underdown Charlton, 1803 S. 15th street, Philadelphia, Pa.

Solomon L. Cherry, 1605 N. 5th street, Philadelphia, Pa.

William Joseph Coleman, University Hospital, Baltimore, Md.

Platt Walker Covington, ———. (Last at Rockingham, N. C.)

Frank Garnett Cowherd, Rockhill, York county, South Carolina.

James Alexander Craig, 613 Jefferson street, Gary, Ind.

W. Cole Davis, First Lieutenant, Medical Corps, U. S. A., now stationed at Manila, P. I.

G. L. Dougherty, 1901 Delaware avenue, Wilmington, Del.

Slocumb Rupert Edwards, Siler City, Chatham county, North Carolina.

William A. Ellingwood, Winterport, Waldo county, Maine.

Oscar W. Fletcher, Sanford, Accomac county, Virginia.

David Franklin, 122 W. Lee street, Baltimore.

George W. Hafele, died May 3, 1911.

William D. Hammond, Hagerstown, Md.

Emil Heller Henning, 2000 Hollins street, Baltimore, Md.

David Ernest Hoag, ———.

J. Howard Hodges, Harper's Ferry, Md.

William Murray Hollyday, 330 N. Charles street, Baltimore, Md.

J. Knox Insley, 2938 E. Baltimore street, Baltimore, Md.

Joseph Connor Joyce, Arnold, Md.

John Daniel Kerr, Jr., Clinton, Sampson county, North Carolina.

Lawrence Kolb, Assistant Surgeon, U. S. P. H. S., Reedy Island, Port Penn, Del.

Louis Charles LaBarre, 924 Hamilton street, Allentown, Pa.

Paul P. Lane, Waycross, Ware county, Georgia.

Charles Evans McBrayer, First Lieutenant, Medical Corps, U. S. A., Fort Howard, Md.

John J. McGarrell, ———.

Allen McLean, Wagram, Scotland county, North Carolina.

John Evans Mackall, died April 4, 1912.

Joaquin S. Miranda y Castillo, Cuba, West Indies.

Elias Nathanson, Summer street, Lynn, Massachusetts.

Verlin Nolt, Columbia City, Whitley county, Indiana.

Lester Dimmitt Norris, 3d street and Central avenue, Cincinnati, O.

Frederick James Pate, Pembroke, Robeson county, North Carolina.

Roy Clifford Potter, ———.

Jaroslav Radda, 230 E. 72d street, New York City.

Russell Wesley Raynor, Vienna, Dorchester county, Maryland.

David Samuel Rhone, 447 Kaighn avenue, Camden, N. J.

Granville Hampton Richards, Port Deposit, Maryland.

Luther Allen Riser, Leesville, Lexington county, South Carolina.

Ramon Luis Rodriguez, San German, Mayaguez county, Porto Rico.

Herbert Jerome Rosenberg, Grant Building, Atlanta, Ga.

Adin Adam Rucker, Rutherfordton, Rutherford county, North Carolina.

Louis Hamilton Seth, McDaniel, Md.

Leo George Scheurich, Tomah, Monroe county, Wisconsin.

Amzi Bedell Shoemaker, North Attleboro, Bristol county, Massachusetts.

Henry Lyon Sinskey, 1610 E. Baltimore street, Baltimore, Md.

Frederick Snyder, 691 Broadway, Kingston, Ulster county, New York.

Arthur Ogburn Spoon, Revolution Mills, Greensboro, N. C.

Leo Fleischer Steindler, 1203 W. North avenue, Baltimore, Md.

D. Hoster Swengel, Mt. Carmel, Abbeville, South Carolina.

James Thomas Taylor, Madison, Rockingham county, North Carolina.

Horace B. Titlow, 3035 O'Donnell street, Baltimore, Md.

Homer Ulric Todd, 737 N. Fulton avenue, Baltimore, Md.

Charles Manly Walters, Union Ridge, Alamance county, North Carolina.

Frederick Chauncey Warring, 1803 St. Paul street, Baltimore, Md.

Henry Harry Weinberger, 724 W. Fayette street, Baltimore Md.

T. Marshall West, Fayetteville, N. C.

Edgar Harold Willard, Mount Pleasant, Md.

Philip R. Williams, ———.

Franklin Davis Wilson, South Norfolk, Va.

Cato Franklin Winslow, dead.

Arthur Leon Wright, 2105 W. Pratt street, Baltimore, Md.

Arturo Zelaya, Nicaragua.

John Edward Berridge Ziegler, Hayward, Wis.

We should be very glad if any of our subscribers would fill in the missing addresses.

tra of the Medical and Chirurgical Faculty of Maryland:

Violins—Drs. Moses J. Lichtenberg, class of 1912; Harry L. Whittle, class of 1903, and Leo John Goldbach, class of 1905.

Trombone—Dr. Harry Stoner, class of 1907.

This is the first physicians' orchestra organized in the United States, though there is one in Berlin and another in Vienna.

Dr. Andres Martin G. de Peralta, class of 1912, is located at Palma Soriano, Oriente, Cuba, where he is doing general medical and surgical work.

Dr. Enrique Llamas is located at 145 N. 18th street, Philadelphia, Pa., where he is visiting dispensary physician to the eye department of Will's Eye Hospital.

Among the University alumni practicing in Kansas are:

Bolton—Christopher Brenner, class of 1906.

Fort Leavenworth—Wm. N. Bispham, class of 1897, Major M. C., U. S. A., Military Prison.

Fort Scott—Robert John Whitfield, class of 1893, Masonic Temple.

Hays—Jos. H. Middlekauff, class of 1879.

Salina—Melcher Gist Cockey, class of 1870.

Wakefield—Charles Hewitt, class of 1868.

## UNDERGRADUATE NOTES

*Under the Supervision of E. Kilbourn Tullidge.*

Messrs. Franklin D. Murphy and Frederick L. McDaniel, members of the senior class, took the United States Civil Service Examinations on Wednesday, February 5, 1913, for positions of physicians (male) in the Indian service.

President Norbert C. Nitsch of the senior class has been confined to his home during the past week by a severe attack of influenza.

The annual dance of the clinical assistants was held Friday evening, January 17, 1913, at Albaugh's Parlors. The patronesses were Mesdames Randolph Winslow, S. E. Neale, Arthur M. Ship-

Dr. Gerardo Vega y Thomas, class of 1912, is at present assisting Professor Fortun, one of Havana's oldest and best-known surgeons, and is located at Espada No. 134, Havana, Cuba.

The following alumni of the University of Maryland are members of the physicians' orches-

Iey, Gordon Wilson, Hiram Woods, John W. Holland, Nathan Winslow and R. H. Johnston. The affair was a decided success, there being plenty to eat, good music, and lots of pretty girls.

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The Delta Chapter of Kappa Psi Fraternity is preparing to hold its annual dance at Schman's Hall on the evening of February 17, 1913.

---

A successful dance was given by the Nu Sigma Nu Fraternity at Albaugh's Parlors Friday evening, January 31, 1913.

---

A delightful theater party was given by the Phi Sigma Kappa Fraternity Friday evening, February 7, 1913, to see Daniel D. Carter's latest play, "The Master Mind."

---

The following invitation has been received by the Kappa Psi Fraternity:

The President and Directors  
of

THE PANAMA-PACIFIC UNIVERSAL EXPOSITION  
to be held in San Francisco in 1915

have the honor to extend to

KAPPA PSI FRATERNITY

A cordial invitation to hold its 1915 meeting in  
San Francisco.

This city has been selected by Congress, with the approval of the President of the United States, as the official site for celebrating the uniting of the waters of the Pacific and Atlantic through the Panama Canal, the greatest physical accomplishment achieved by man. The Exposition will not only attempt to show that which is most advanced in Invention, most interesting in Art and of greatest scientific value, embracing all that is most important in the material progress of the world, but it will be the aim of the directors to make it rank in intellectual interest above all previous expositions; to bring together so much of wisdom, so much of practical scientific thought and so much of broad grasp of the world's important problems that the progress of mankind shall be advanced a quarter of a century.

To assist in achieving this aim, we invite your

presence in the city of San Francisco in the year Nineteen Hundred and Fifteen.

BENJ. I. WHEELER,

*President, University of California.*

DAVID STARR JORDEN,

*President, Leland Stanford University.*

RUDOLPH J. TANSIG,

*Chairman, Committee on Exposition.*

WM. BRISBANE WALKER,

*Director of Congresses.*

CHAS. I. MOORE,

*President.*

F. S. STIFFE,

*Director-in-Chief of Foreign and Domestic Participation.*

[SEAL.]

---

An examination in major surgery was given in Davidge Hall by Prof. Randolph Winslow to the members of the senior class on Tuesday, February 4, 1913.

---

Prof. Hiram Woods has announced that he will hold his final examination on the eye for the senior class early in February.

---

William Frank McDaniel of the freshman medical class, who has been confined to the hospital with an attack of chronic appendicitis, has recovered.

---

At the State Board examinations, held in Maryland recently, two members of the senior class made exceptionally good showings—Leonard Hays received a general average of 85 per cent. and Ross B. Kolb an average of 82 per cent.

---

Examinations for entrance to Bayview Hospital were held on Tuesday, February 7, 1913. The subjects were medicine, surgery and clinical pathology.

---

On Wednesday, February 5, Dr. C. W. Stiles, U. S. P. H. S., gave an illustrated lantern lecture in Chemical Hall on the "Hookworm."

---

Other weekly lectures on Tropical Medicine by members of the U. S. Public Health Service have been arranged by Professor Zueblin, to be held in Anatomical Hall on Tuesday of each week at 2 o'clock P. M.

Students desirous of taking the Pennsylvania State Board Examination in June will be required to show evidence of having delivered six obstetrical cases, assisted in six surgical operations, administered six anesthetics and witnessed six autopsies.

The first of a series of interesting and instructive clinics conducted by Prof. Irving J. Spear on mental diseases at Bayview Hospital was held on Saturday, February 1, 1913, the subject being stigmata, degeneration, imbecility and idiocy. Professor Spear has announced his remaining clinics to be as follows: Dementia precox, paranoia, February 15; general paresis, March 1; senility and organic dementia, March 8; psychosis due to intoxication, March 5; maniacal and depressive insanity.

Prof. L. E. Neale desires to announce through THE BULLETIN that he will welcome all candidates of the senior class desiring internship in the obstetrical department of the hospital at his home, 106 E. Read street.

A communication from Dr. N. Travis Gibbs of 42 W. 75th street, New York, states that there are several vacancies at Blackwell's Island, and requests those desiring internship there to communicate with him at their earliest convenience.

The price of Terra Mariae will be \$2.50 if a deposit of \$1 is made with Editor-in-Chief Breeding before March 1, otherwise \$3 per copy will be charged.

## MARRIAGES

Dr. James Erwin Diehl, class of 1911, was married on Saturday morning, January 18, 1913, at 11.30 o'clock, in Raleigh, N. C., to Miss Lillie May, daughter of Mrs. Mary Eleanor Tucker of Raleigh, N. C. Dr. and Mrs. Diehl will be at home after February 1 at the Trenton State Hospital.

Dr. William Herbert Pearce, class of 1891, of 2105 N. Charles street, Baltimore, was married on Tuesday, February 4, 1913, to Miss Sarah Frances Ferguson, daughter of Mrs. Hugh Fer-

guson, of Charleston, S. C. The couple were married at the home of the bride, 21 George street. The ceremony was performed by Rev. Dr. Duffy Lill, and was witnessed by members of the two families only. Dr. and Mrs. Pearce will be at home after February 10 at 2105 N. Charles street.

## DEATHS

Dr. Robert John Price, class of 1866, died at his home in Vienna, Md., January 15, 1913, of paralysis, aged 73 years. Dr. Price was born in Centreville, Md., October 13, 1838. He was the son of John C. and Elizabeth Downing Price, both natives of Maryland and descendants of English ancestors. He was educated in the public schools of Baltimore, Centreville Academy and the University of Maryland. He also attended clinical lectures in the University Hospital, and in the same year in which he graduated entered upon his professional career at Vienna. He was one of the best known and most popular physicians in Dorchester county, and one of the most successful.

Dr. Price was at one time a member of the School Board, and for many years physician to the almshouse.

He was twice married, and is survived by the following children by his first wife, who was Miss Laura Jump of Queen Anne: Mrs. Charles Hearn, Mrs. Jacob Cook and Miss Emma Price of Baltimore; Mrs. Lloyd G. LeCompte of Vienna and Alfred Price of Philadelphia; and by his second marriage, to Miss Emma Lester of Richmond, Va., by the following three children: Lester, Benson and Richmond Price.

Dr. Edward Lawrence Casey, class of 1905, died at his home in North Woodstock, N. H., December 10, 1912, aged 30 years.

Dr. George W. Davis, class of 1869, died on Sunday, January 19, 1913, at his home near Pleasantville, Md., aged 69 years. Dr. Davis had been in ill-health for some time, and his death was not unexpected. He is survived by his widow, who was Miss Mary J. Beaumont. Dr. Davis enjoyed a large and lucrative practice, and was much beloved. He was buried on Wednesday, January 22, at the Old Baptist Church, Jarrettsville, Md.



# HOSPITAL BULLETIN

## OF THE

# UNIVERSITY OF MARYLAND

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